

Love, Sex, and Marriage in the Setting of Pathological Narcissism

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Mature love requires the establishment of a sustained relationship with a romantically attractive, non-incestuous object toward whom a certain amount of ambivalence can be tolerated and in relationship with whom affection and sensuality can both be expressed and received. This concept underscores the necessity to have mastered the oedipal realities of childhood (eg, feelings of smallness, rivalry, and exclusion) and to have found a love object that is neither a replica of the primary oedipal love object nor utterly devoid of its qualities. Besides this, capacity for separateness, respect for the lover's autonomy, and affects of tenderness and care need to be brought under the spectrum of experiences collectively called "love."

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The individual with a narcissistic personality has not mastered these developmental tasks. Feeling deprived from the earliest periods of childhood onwards, he is seething with rage. This rage makes tolerating limits that are inherent in oedipal realities difficult. Tenderness and restrained sexuality is replaced by oral greed and cocky irreverence. This, as can be readily imagined, has a wide-ranging impact upon the evolution and sustenance of romantic and sexual life during adulthood.

Such multifaceted impact of pathological narcissism upon love relations forms a topic of this contribution. I will elucidate the resulting dynamics and phenomenology under three separate headings: narcissism and romantic love, narcissism and sexuality, and narcissism and marriage. In each of these areas, I will delineate observable problems and subjective areas of distress, taking gender differences into account.

NARCISSISM AND ROMANTIC LOVE

Freud's seminal statement of 1912¹ still forms the cornerstone of the psychoanalytic understanding of love. He noted "two currents whose union is necessary to ensure a completely normal attitude in love ... These two may be distinguished as the affectionate and sensual current."¹ The affectionate current is ontogenetically the earlier one. It arises in connection with the early body and emotional care provided by the mother. The second, more specifically sexual, current arrives on the scene during the oedipal phase and then, with full force, during puberty. It has to be synthesized with the affectionate current. Romantic love can then be expressed towards nonfamilial objects with whom a sexual union is permissible and possible.

Freud² later addressed the topic of love from a different perspective. He distinguished between narcissistic love (arising from the ego's self-affirming needs) and anaclitic love (arising from

the ego's desire for the object's helping qualities). He emphasized that the highest phase of development of which object libido is capable is seen in the state of being in love. "A person who loves has, so to speak, forfeited a part of his narcissism, and it can only be replaced by his being loved ... Loving in itself, insofar as it involves a longing and deprivation, lowers self regard; whereas being loved, having one's love returned, and possessing the love object raises it once more." Freud³ also noted that a synthesis of libidinal and aggressive aims is necessary for true love. Still later, he traced the idealization of the love object to its "being treated in the same way as our own ego, so that when we are in love a considerable amount of narcissistic libido overflows onto the object."⁴ Although acknowledging the exaltation that accompanies love, Freud emphasized the potential of pain in it: "We are never so defenseless as when we love."⁵ He went on to note that many individuals protect themselves against the possibility of such pain by directing their love not to one person but to mankind in general and its cultural institutions.

Following Freud, many psychoanalysts made significant contributions to our understanding of love. I have elsewhere⁶ synthesized this literature. Here, I will mention Chassagueut-Smirgel's⁷ elucidation of the picture of the ego ideal within the context of mature love and by citing Kernberg's⁸ comprehensive psychoanalytic definition of love. Chassagueut-Smirgel⁷ noted that the four elements characterize the healthy amalgamation of narcissism and love: 1) the nostalgic search for oneness with the primary object is not given up, but the ways of achieving it become different; 2) the sexual satisfaction within the couple and their autonomous sublimations enhance secondary narcissism of the ego and diminish the ego-ego ideal gap; 3) those aspects of internal and external reality that facilitate these sexual and

narcissistic gratifications get positively cathected, and the ego ideal is, to some extent, projected on the very means of access to such realities; and 4) the narcissistic pain over remnant longings for oneness with primary objects and incestuous gratifications is compensated for by the attachment to the love object and its sustained availability.

Kernberg, in keeping with the impressive breadth and depth of his contributions to the study of love⁸⁻¹³ offered a detailed definition of love that synthesizes all its important aspects. According to this definition, mature love is a complex emotional disposition that integrates "1) sexual excitement transformed into erotic desire for another person; 2) tenderness that derives from the integration of libidinally and aggressively invested self and object representations, with a predominance of love over aggression and tolerance of the normal ambivalence that characterizes all human relations; 3) an identification with the other that includes both a reciprocal genital identification and deep empathy with the other's gender identity; 4) a mature form of idealization along with deep commitment to the other and to the relationship; and 5) the passionate character of the love relation in all three aspects: the sexual relationship, the object relationship, and the superego investment of the couple."⁸

Such love leads to recovery of lost parts of the self, dissolves sexual inhibitions, and gives purpose to life. The initial passion might be brief, but the capacity of the two partners for deep relations helps them convert this burning flame into a lambent glow of companionship.

With this as a backdrop, let me move on to the deleterious effects of excessive narcissism upon the affectionate and sensual dimensions of love. Freud's affectionate current¹ has never been explicitly deconstructed into its components. In my view, however, it comprises of the capacities for concern; curiosity; empathic listening; optimal distance;

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place. In two fixed-dose studies, the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro was not significantly different from the rate of discontinuation for adverse events in patients receiving placebo. The rate of discontinuation for adverse events in patients assigned to a fixed dose of 20 mg/day Lexapro was 10%, which was significantly different from the rate of discontinuation for adverse events in patients receiving 10 mg/day Lexapro (4%) and placebo (3%). Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice that of placebo, were nausea (2%) and ejaculation disorder (2% of male patients). **Generalized Anxiety Disorder** Among the 429 GAD patients who received Lexapro 10-20 mg/day in placebo-controlled trials, 8% discontinued treatment due to an adverse event, as compared to 4% of 427 patients receiving placebo. Adverse events that were associated with the discontinuation of at least 1% of patients treated with Lexapro, and for which the rate was at least twice the placebo rate, were nausea (2%), insomnia (1%), and fatigue (1%).

Incidence of Adverse Events in Placebo-Controlled Clinical Trials Major Depressive Disorder Table 2 enumerates the incidence, rounded to the nearest percent, of treatment-emergent adverse events that occurred among 715 depressed patients who received Lexapro at doses ranging from 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The prescriber should be aware that these figures cannot be used to predict the incidence of adverse events in the course of usual medical practice where patient characteristics and other factors differ from those which prevailed in the clinical trials. Similarly, the cited frequencies cannot be compared with figures obtained from other clinical investigations involving different treatments, uses, and investigators. The cited figures, however, do provide the prescribing physician with some basis for estimating the relative contribution of drug and non-drug factors to the adverse event incidence rate in the population studied. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were insomnia, ejaculation disorder (primarily ejaculatory delay), nausea, sweating increased, fatigue, and somnolence (see TABLE 2). **TABLE 2: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Major Depressive Disorder* (Percentage of Patients Reporting Event) Body System/Adverse Event (Lexapro (N=715) and Placebo (N=592)):** Autonomic Nervous System Disorders: Dry Mouth (6% and 5%); Sweating Increased (5% and 2%); Central & Peripheral Nervous System Disorders: Dizziness (5% and 3%); Gastrointestinal Disorders: Nausea (15% and 7%); Diarrhea (8% and 5%); Constipation (3% and 1%); Indigestion (3% and 1%); Abdominal Pain (2% and 1%). **General:** Influenza-like symptoms (5% and 4%); Fatigue (5% and 2%). **Psychiatric Disorders:** Insomnia (9% and 4%); Somnolence (6% and 2%); Appetite Decreased (3% and 1%); Libido Decreased (3% and 1%). **Respiratory System Disorders:** Rhinitis (5% and 4%); Sinusitis (3% and 2%). **Urogenital:** Ejaculation Disorder[†] (9% and <1%); Impotence[‡] (3% and <1%); Anorgasmia[§] (2% and <1%). *Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo > Lexapro: headache, upper respiratory tract infection, back pain, pharyngitis, inflamed injury, anxiety. [†]Primarily ejaculatory delay. [‡]Denominator used was for males only (N=225 Lexapro; N=188 placebo). [§]Denominator used was for females only (N=490 Lexapro; N=404 placebo). **Generalized Anxiety Disorder Table 3** enumerates the incidence, rounded to the nearest percent of treatment-emergent adverse events that occurred among 429 GAD patients who received Lexapro 10 to 20 mg/day in placebo-controlled trials. Events included are those occurring in 2% or more of patients treated with Lexapro and for which the incidence in patients treated with Lexapro was greater than the incidence in placebo-treated patients. The most commonly observed adverse events in Lexapro patients (incidence of approximately 5% or greater and approximately twice the incidence in placebo patients) were nausea, ejaculation disorder (primarily ejaculatory delay), insomnia, fatigue, decreased libido, and anorgasmia (see TABLE 3). **TABLE 3: Treatment-Emergent Adverse Events: Incidence in Placebo-Controlled Clinical Trials for Generalized Anxiety Disorder* (Percentage of Patients Reporting Event) Body System/Adverse Event (Lexapro (N=429) and Placebo (N=427)):** Autonomic Nervous System Disorders: Dry Mouth (9% and 5%); Sweating Increased (4% and 1%); Central & Peripheral Nervous System Disorders: Headache (24% and 17%); Paresthesia (2% and 1%); Gastrointestinal Disorders: Nausea (18% and 8%); Diarrhea (8% and 6%); Constipation (5% and 4%); Indigestion (3% and 2%); Vomiting (3% and 1%); Abdominal Pain (2% and 1%); Flatulence (2% and 1%); Toothache (2% and 0%). **General:** Fatigue (8% and 2%); Influenza-like symptoms (5% and 4%). **Musculoskeletal:** Neck/Shoulder Pain (3% and 1%). **Psychiatric Disorders:** Somnolence (13% and 7%); Insomnia (12% and 6%); Libido Decreased (7% and 2%); Dreaming Abnormal (3% and 2%); Appetite Decreased (3% and 1%); Lethargy (3% and 1%); Yawning (2% and 1%). **Urogenital:** Ejaculation Disorder[†] (14% and 2%); Anorgasmia[‡] (6% and <1%); Menstrual Disorder (2% and 1%). *Events reported by at least 2% of patients treated with Lexapro are reported, except for the following events which had an incidence on placebo > Lexapro: inflamed injury, dizziness, back pain, upper respiratory tract infection, rhinitis, pharyngitis. [†]Primarily ejaculatory delay. [‡]Denominator used was for males only (N=182 Lexapro; N=195 placebo). [§]Denominator used was for females only (N=247 Lexapro; N=232 placebo). **Dose Dependency of Adverse Events** The potential dose dependency of common adverse events (defined as an incidence rate of $\geq 5\%$ in either the 10 mg or 20 mg Lexapro groups) was examined on the basis of the combined incidence of adverse events in two fixed-dose trials. The overall incidence rates of adverse events in 10 mg Lexapro-treated patients (66%) was similar to that of the placebo-treated patients (61%), while the incidence rate in 20 mg/day Lexapro-treated patients was greater (86%). **Table 4** shows common adverse events that occurred in the 20 mg/day Lexapro group with an incidence that was approximately twice that of the 10 mg/day Lexapro group and approximately twice that of the placebo group. **TABLE 4: Incidence of Common Adverse Events* in Patients with Major Depressive Disorder Receiving Placebo (N=511), 10 mg/day Lexapro (N=310), 20 mg/day Lexapro (N=125):** Insomnia (14%, 7%, 14%), Diarrhea (5%, 6%, 14%), Dry Mouth (3%, 4%, 9%), Somnolence (1%, 4%, 9%), Dizziness (2%, 4%, 7%), Sweating Increased (<1%, 3%, 8%), Constipation (1%, 3%, 6%), Fatigue (2%, 2%, 6%), Indigestion (1%, 2%, 5%). *Adverse events with an incidence rate of at least 5% in either of the Lexapro groups and with an incidence rate in the 20 mg/day Lexapro group that was approximately twice that of the 10 mg/day Lexapro group and the placebo group. **Male and Female Sexual Dysfunction with SSRIs:** Although changes in sexual desire, sexual performance, and sexual satisfaction often occur as manifestations of a psychiatric disorder, they may also be a consequence of pharmacologic treatment. In particular, some evidence suggests that SSRIs can cause such untoward sexual experiences. Reliable estimates of the incidence and severity of untoward experiences involving sexual desire, performance, and satisfaction are difficult to obtain, however, in part because patients and physicians may be reluctant to discuss them. Accordingly, estimates of the incidence of untoward sexual experience and performance cited in product labeling are likely to underestimate their actual incidence. **Table 5** shows the incidence rates of sexual side effects in patients with major depressive disorder and GAD in placebo-controlled trials. **TABLE 5: Incidence of Sexual Side Effects in Placebo-Controlled Clinical Trials (In Males Only: Adverse Event: Lexapro (N=407) (N=383)):** Ejaculation Disorder (primarily ejaculatory delay) (12% and 1%); Libido Decreased (6% and 2%); Impotence (2% and <1%). [In Females Only: Lexapro (N=737) and Placebo (N=636)]: Libido Decreased (3% and 1%); Anorgasmia (3% and <1%). There are no adequately designed studies examining sexual dysfunction with escitalopram treatment. Priapism has been reported with all SSRIs. While it is difficult to know the precise risk of sexual dysfunction associated with the use of SSRIs, physicians should routinely inquire about such possible side effects. **Vital Sign Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in vital signs (pulse, systolic blood pressure, and diastolic blood pressure) and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses did not reveal any clinically important changes in vital signs associated with Lexapro treatment. In addition, a comparison of supine and standing vital sign measures in subjects receiving Lexapro indicated that Lexapro treatment is not associated with orthostatic changes. **Weight Changes** Patients treated with Lexapro in controlled trials did not differ from placebo-treated patients with regard to clinically important change in body weight. **Laboratory Changes** Lexapro and placebo groups were compared with respect to (1) mean change from baseline in various serum chemistry, hematology, and urinalysis variables, and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed no clinically important changes in laboratory test parameters associated with Lexapro treatment. **ECG Changes** Electrocardiograms from Lexapro (N=625), racemic citalopram (N=511), and placebo (N=527) groups were compared with respect to (1) mean change from baseline in various ECG parameters and (2) the incidence of patients meeting criteria for potentially clinically significant changes from baseline in these variables. These analyses revealed (1) a decrease in heart rate of 2.2 bpm for Lexapro and 2.7 bpm for racemic citalopram, compared to an increase of 0.3 bpm for placebo and (2) an increase in QTc interval of 3.9 msec for Lexapro and 3.7 msec for racemic citalopram, compared to 0.5 msec for placebo. Neither Lexapro nor racemic citalopram were associated with the development of clinically significant ECG abnormalities. **Other Events Observed During the Premarketing Evaluation of Lexapro** Following is a list of WHO terms that reflect treatment-emergent adverse events, as defined in the introduction to the ADVERSE REACTIONS section, reported by the 1428 patients treated with Lexapro for periods of up to one year in double-blind or open-label clinical trials during its premarketing evaluation. All reported events are included except those already listed in Tables 2 & 3, those occurring in only one patient, event terms that are so general as to be uninformative, and those that are unlikely to be drug related. It is important to emphasize that, although the events reported occurred during treatment with Lexapro, they were not necessarily caused by it. Events are further categorized by body system and listed in order of decreasing frequency according to the following definitions: frequent adverse events are those occurring on one or more occasions in at least 1/100 patients; infrequent adverse events are those occurring in less than 1/100 patients but at least 1/1000 patients. **Cardiovascular - Frequent:** palpitation, hypertension. **Infrequent:** bradycardia, tachycardia, ECG abnormal, flushing, varicose vein. **Central and Peripheral Nervous System Disorders - Frequent:** light-headed feeling, migraine. **Infrequent:** tremor, vertigo, restless legs, shaking, twitching, dysequilibrium, tics, carpal tunnel syndrome, muscle contractions involuntary, sluggishness, coordination abnormal, faintness, hyperreflexia, muscular tone increased. **Gastrointestinal Disorders - Frequent:** heartburn, abdominal cramp, gastroenteritis. **Infrequent:** gastroesophageal reflux, bloating, abdominal discomfort, dyspepsia, increased stool frequency, belching, gastritis, hemorrhoids, gagging, polyposis gastric, swallowing difficult. **General - Frequent:** allergy, pain in limb, fever, hot flushes, chest pain. **Infrequent:** edema of extremities, chills, tightness of chest, leg pain, asthenia, syncope, malaise, anaphylaxis, fall. **Hemic and Lymphatic Disorders - Frequent:** bruise, anemia, nosebleed, hematoma, lymphadenopathy cervical. **Metabolic and Nutritional Disorders - Frequent:** increased weight. **Infrequent:** decreased weight, hyperglycemia, thirst, bilirubin increased, hepatic enzymes increased, gout, hypercholesterolemia. **Musculoskeletal System Disorders - Frequent:** arthralgia, myalgia. **Infrequent:** jaw stiffness, muscle cramp, muscle stiffness, arthritis, muscle weakness, back discomfort, arthralgia, jaw pain, joint stiffness. **Psychiatric Disorders - Frequent:** appetite increased, lethargy, irritability, concentration impaired. **Infrequent:** jitteriness, panic reaction, agitation, apathy, forgetfulness, depression aggravated, nervousness, restlessness aggravated, suicide attempt, amnesia, anxiety attack, bruxism, carbohydrate craving, confusion, depersonalization, disorientation, emotional lability, feeling unreal, tremulousness nervous, crying abnormal, depression, excitability, auditory hallucination, suicidal tendency. **Reproductive Disorders/Female - Frequent:** menstrual cramps, menstrual disorder. **Infrequent:** menorrhagia, breast neoplasm, pelvic inflammation, premenstrual syndrome, spotting between menses. *% based on female subjects only; N=905. **Respiratory System Disorders - Frequent:** bronchitis, sinus congestion, coughing, nasal congestion, sinus headache. **Infrequent:** asthma, breath shortness, laryngitis, pneumonia, tracheitis. **Skin and Appendages Disorders - Frequent:** rash. **Infrequent:** pruritus, acne, alopecia, eczema, dermatitis, dry skin, folliculitis, lipoma, furunculosis, dry lips, skin nodule. **Special Senses - Frequent:** vision blurred, tinnitus. **Infrequent:** taste alteration, earache, conjunctivitis, vision abnormal, dry eyes, eye irritation, visual disturbance, eye infection, pupils dilated, metallic taste. **Urinary System Disorders - Frequent:** urinary frequency, urinary tract infection. **Infrequent:** urinary urgency, kidney stone, dysuria, blood in urine. **Events Reported Subsequent to the Marketing of Escitalopram** - Although no causal relationship to escitalopram treatment has been found, the following adverse events have been reported to have occurred in patients and to be temporally associated with escitalopram treatment during postmarketing spontaneous and clinical trial experience and were not observed during the premarketing evaluation of escitalopram: Blood and Lymphatic System Disorders: hemolytic anemia, leukopenia, thrombocytopenia. Cardiac Disorders: atrial fibrillation, cardiac failure, myocardial infarction, torsade de pointes, ventricular arrhythmia, ventricular tachycardia. Endocrine Disorders: diabetes mellitus, hyperprolactinemia, SIADH. Eye Disorders: diplopia, glaucoma. Gastrointestinal Disorders: gastrointestinal hemorrhage, pancreatitis, rectal hemorrhage. General Disorders and Administration Site Conditions: abnormal gait. Hepatobiliary Disorders: fulminant hepatitis, hepatic failure, hepatic necrosis, hepatitis. Immune System Disorders: allergic reaction. Investigations: electrocardiogram QT prolonged, INR increased, prothrombin decreased. Metabolism and Nutrition Disorders: hypoglycemia, hypokalemia. Musculoskeletal and Connective Tissue Disorders: rhabdomyolysis. Nervous System Disorders: akathisia, choreoathetosis, dysarthria, dyskinesia, dystonia, extrapyramidal disorders, grand mal seizure (or convulsions), hypoesthesia, myoclonus, nystagmus, seizures, tardive dyskinesia. Pregnancy, Parturition and Perinatal Conditions: spontaneous abortion. Psychiatric Disorders: acute psychosis, aggression, anger, delirium, delusion, nightmare, paranoia, visual hallucinations. Renal and Urinary Disorders: acute renal failure. Reproductive System and Breast Disorders: priapism. Respiratory, Thoracic and Mediastinal Disorders: pulmonary embolism. Skin and Subcutaneous Tissue Disorders: angioedema, ecchymosis, erythema multiforme, photosensitivity reaction, Stevens Johnson Syndrome, toxic epidermal necrolysis, urticaria. Vascular Disorders: deep vein thrombosis, hypotension, orthostatic hypotension, phlebitis, thrombosis. Forest Pharmaceuticals, Inc. Subsidiary of Forest Laboratories, Inc. St. Louis, MO 63045 USA Licensed from H. Lundbeck A/S Rev. 01/09 © 2009 Forest Laboratories, Inc.

forgiveness; and gratitude, which, in turn, gives rise to reciprocity and reparation. **Individuals with narcissistic personality** have difficulties with all these functions. They **forget the important dates in the lives of their lovers, fail to ask about their lover's families, become strangely inarticulate when it comes to protecting their lovers in an argument with others, and cannot titrate their demands in tandem with their lover's changing psychophysiological states. The capacity for curiosity and attentive listening is similarly impaired.**

Narcissistic individuals also have difficulty in maintaining optimal distance. The capacity to maintain optimal distance is essentially based upon a paradox.¹⁴⁻¹⁶ On the one hand, the lovers have to tolerate a relative loss of autonomy and self-sufficiency. On the other hand, they have to accept each other's essential separateness; after all, they have been raised by different sets of parents and grew up under different psychosocial circumstances. The narcissistic individual has difficulty in tolerating either side of this relational equation. He or she does not wish to renounce total autonomy while also not permitting a separate mental life to the other. Under the pressure of instinctual drives, the narcissistic individual comes too close to the other person and defending against the aggression, inevitably mobilized by intimacy, he withdraws and becomes cold and aloof. In contrast with the mature relatedness in love that gradually deepens, **narcissistic relatedness is characterized by cycles of need-based intimacy and defensive withdrawal.**

In essence, the affectionate current of love (concern, curiosity, empathy, optimal distance, forgiveness, and gratitude) requires that we allow someone to enter our hearts. In meta-psychological terms, this is a major libidinal cathexis of an object. In a different psychoanalytic idiom, affection is the provision of inner space for a co-created and affectively positive relational dialogue. Regardless of the terminology, such development is possible only when the core self-representation of the individual does not need constant polishing and attention. **Winnicott's¹⁷ phrase, "ordinarily devoted mother," has a readymade counterpart in my profile of the ordinarily devoted lover. The narcissistic individual is certainly not one.**

I must acknowledge that I have not discussed two important issues here. One pertains to the sensual current of romantic love and the other to the object choice in the realm of love and marriage. I intend to take these two topics up in the following sections on narcissism and sexuality, and narcissism and marriage, respectively.

NARCISSISM AND SEXUALITY

The existing literature on narcissism and sexuality largely addresses sexual object choice. Among the scenarios outlined are the search for a "heterosexual twin,"¹⁸ Don-Juan syndrome, persistent Madonna-whore dichotomy, early sexual promis-

cuity of the usual narcissist and the late promiscuity of the shy narcissist,¹⁸ narcissistically determined male homosexuality, narcissistic women's gravitating to famous men, and some narcissistic women's totally turning away from heterosexuality into celibacy or lesbian lifestyle. In regressed narcissistic men, especially those leading socially isolated or religiously dictated celibate lives, secret addiction to masturbation, and vulnerability to pedophilia is also evident. Although such phenomena and the psychodynamics underlying them are indeed important, in the following passages I will concentrate upon the impact of excessive narcissism upon the actual act of heterosexual intercourse since this has not received adequate attention in the literature.

In order to illustrate how pathological narcissism impacts upon sexual intercourse, it might be worthwhile to first recount the usual sequence of events associated with it. This includes: 1) subtle hints from the partners for readiness, 2) initial foreplay while being dressed, 3) undressing and "foreplay proper," 4) penetration and intercourse, 5) orgasm, 6) post-orgasmic tenderness, and 7) return to conventional morality and non-sexual behavior by putting clothes back on and beginning to talk about other matters, with or without an interlude of sleep. At each step of this sequence (admittedly, robbed of innovation and surprise for didactic ease), pathological narcissism might cause problems.

Deficient in the capacity for empathic attunement, the narcissistic individual often fails to discern signals of readiness from the romantic partner. The narcissist might also not feel the need to subtly convey his own desire since he assumes that his need will automatically be met with gratification. Worse still, the narcissist might deliberately overlook the partner's appeal signals in order to sadistically withhold affection from them. At such moments, the narcissist's identifi-

cation with the depriving mother of early childhood is unmistakably evident.

Similar problems characterize the early foreplay. The narcissist shows a proclivity to disregard the partner's needs, lacks tenderness, and tends to move too quickly toward the next step. The "foreplay proper" involves undressing, facing each other naked, and stimulating each other in ways other than genital-to-genital contact. Shedding one's shame over nakedness and gently overcoming the partner's shame are important tasks here. Fears regarding the real and imaginary blemishes of one's body have to be put aside. For this, genuine self-regard and trust in the partner's goodness is needed. The narcissist lacks both and is therefore uncomfortable with foreplay. Some narcissistic men, however, hide such discomfort by "humbly" serving their partner's needs — rather like the vagina man described by Limentani¹⁹ or by prolonging the foreplay in a counterphobic exhibition of their sexual prowess.

Yet another important aspect of the foreplay is the emergence into consciousness of pregenital-drive derivatives (eg, sucking, biting, licking, showing, looking, squeezing, smelling, inflicting small amounts of pain). The narcissist, who has kept his immense oral hunger and anally defiling impulses tightly tucked underneath his glittering persona now vacillates between indulgent greed and anxious retreat. As a result, the partner ends up confused and frustrated.

Encountering the naked body of an opposite sex partner also stirs up the narcissist in other ways. According to Kernberg,⁸ "... unconscious envy of the other transforms the idealization of the other's body into its devaluation, fosters the transformation of sexual gratification into the sense of having successfully invaded and incorporated the other, eliminates the richness of the primitive object relations activated in normal polymorphous perverse sexuality, and descends into boredom."⁸

Over time, such boredom might manifest through a diminution in the frequency of sexual intercourse. During the intercourse itself, this might be combated by postural gymnastics and penetrative experimentations of all sorts. With physiologically plausible truisms and rationalizations, narcissistic men prefer entering a woman from behind, and narcissistic women prefer performing intercourse while being on top. Both thus avoid face-to-face closeness and seek greater physical control over their own movements. This search is driven by the enhanced orgasmic potential of such postures as well as their narcissistically stabilizing effects. The more control the narcissists have, the more pleasure they draw from sex.

Achieving orgasm, however, is difficult for narcissistic individuals since the experience requires dyscontrol and a temporary loss of self. Narcissistic women might therefore feel compelled to fake orgasms, especially if their partners regard that as a sexual trophy. Narcissistic men might transform their difficulty in ejaculating and reaching orgasm — based upon the identification of their penis with a depriving maternal breast — into the masculine glory of being able to carry on intercourse for long lengths of time.

The post-orgasmic phase offers a wonderful opportunity of "lying fallow"²⁰ in the presence of another individual. Winnicott¹⁷ makes a special note of this part of sexual act in his article on mature aloneness: "It is perhaps fair to say that after satisfactory intercourse each partner is alone, and it contented to be alone. Being able to enjoy being alone along with another person who is also alone is in itself an experience of health. Lack of id-tension may produce anxiety, but time-integration of the personality enables the individual to wait for the natural return of id-tension, and to enjoy sharing solitude, that is to say, solitude that is relatively free from the property that we call 'withdrawal.'"

Mutual tenderness, holding, and gentle caressing characterizes this phase, which is also sprinkled with looking into each others' eyes, sleepy smiles, and an occasional child-like laughter. All this requires a resurgent dominance of the affectionate current of love and poses problems for the narcissistic individual. The closure of the sexual interlude and return to conventional morality via dressing and resumption of non-sexual activities is similarly hard for the narcissist. He either ends it all abruptly or continues to inject the erotic into the post-sexual, ordinary behavior, and conversation.

In essence, from the awakening of desire through foreplay to orgasm and post-orgasmic states, the narcissist finds matters difficult. According to Bach,²¹ such an individual cannot manage normal sexuality, which "requires the capacity to simultaneously enjoy oneself as a subject and as object by identifying with the object; it requires the capacity to accept objects that differ from oneself."²¹ Bach goes on to say that narcissistic individuals "have generally made peace with reality on condition that they don't always have to live in it. They inhabit the world without being embedded in it. The interpenetration and mutual enrichment of inner life and reality are a problem for them, a problem concretely exemplified by their difficulty in coordinating self-love and object-love ... They can be either "all themselves" or "all somebody's lover," but seem to find it difficult or impossible to integrate or articulate these two apparently complementary views on the self."²¹

The normal homeostasis in which the self experience and concern for others exist in an intermingled state is beyond the narcissistic individual. This is a major handicap in the enjoyment of sexuality and poses difficulties for marital life where development and maintenance of mutuality — in Bergman's terms,²² "true we/our experience" — is the central issue at stake.

NARCISSISM AND MARRIAGE

The decision to marry and the subsequent establishment and maintenance of marital couplehood pose new challenges while also offer new gratifications to the two individuals in the dyad. The most prominent among the challenges is the need to renounce the ideal spouse representation,²³ an exalted, internal image comprising of the most desirable attributes of all the consummated and unrequited loves of adolescence and young adulthood (on the preconscious level) and of the best qualities of the two parents (on the unconscious level). This mobilizes frustration, mental pain,²⁴ and aggression, which, under fortunate circumstances, turn out to be bearable.

Difficult psychological tasks do not end with entry into marriage. Indeed, a marriage is sustained by attending to intrapsychic and interpersonal challenges that keep cropping up. It can only "survive and thrive if the partners are cognizant of difficulties, as they arise, communicate their feelings to each other, and resolve their differences. There must be a real commitment to their relationship, which, in turn, will encourage the compromises that are needed."²⁵

Disillusionment in oneself and the partner, disagreements over childrearing, the necessity to make sacrifices for the sake of one's partner, firm maintenance of the couple's social and monetary privacy, and resisting extramarital erotic temptations are all part of this picture. The frequent decline of sexual excitement in the setting of an ongoing marriage is a problem as well. Freud, while showing a greater optimism towards second marriages,^{26,27} held on to the idea that marriage reduces the intensity of erotic pleasure. He declared that "the psychological value of erotic needs is reduced as soon as their satisfaction becomes easy."²¹ Further dynamics underlying this was elucidated by his followers. Colarusso²⁸ suggested that sexual relations in a married couple become

oedipally re-charged, hence potentially awkward, after the arrival of children. Ross²⁹ underscored the spoiling effect of the shadow of early parental imagos — especially of a homosexual nature — upon marital sexuality. And long before these contemporary formulations, Horney declared parental transferences in marriage to be the "fundamental problem in monogamy."³⁰ All in all, entering into a marriage and sustaining it over time are not easy.

At the same time, the experience can be profoundly gratifying if the partners bring solid psychic structures of their own, have chosen each other thoughtfully, and have the necessary forbearance for meeting the above mentioned challenges. Under such circumstances, the illusory search for perfection gives way to the enriching pleasure of psychic stability and depth. Favors to the partner no longer seem like sacrifices; they become the moral foundations of the couplehood itself. Value systems of the two partners mutually enhance each other, and raising children together offers possibilities of re-working remnant internal conflicts, transcending history, and fostering the couple's existential optimism. Narcissistic and anaclitic love become interchangeable,⁷ so that loving the partner becomes synonymous with loving oneself and taking good care of oneself transforms into giving a gift to one's partner. Even sexuality, while losing some of its initial magic, acquires a deeper emotional anchor. The spouse's body becomes a depository of one's internal objects and the "geography of personal meanings."

It should be now be clear that the complexities of mourning and disillusionment on the one hand, and mental deepening and civilized interpersonal merger on the other hand, are too much for a narcissistic individual's ego to bear. Marrying and staying married thus become difficult. Four types of pathological outcomes tend to result.

First, there might develop a severe inhibition in the capacity to marry. Although largely based upon the preconsciously sensed inability to metabolize aggression in the crucible of a dyadic relationship, the inhibition might have additional origins that differ in the two genders. In narcissistic men, the inability to marry might arise from the unrelenting quest for sexual encounters, rationalized on the basis of male biological imperatives or as simply looking for a perfect partner. In narcissistic women, the inability to marry might arise from their inordinate pleasure in self-sufficiency which, in turn, hides anxiety over attachment and dependence. In both men and women, these dynamics forcefully resurface after the failure of a first marriage and might delay, if not thwart, finding an acceptable partner for a second marriage.

Second, narcissistic personalities tend to select individuals who, rather than help diminish their pathology, aid in retaining their aggrandized view of themselves. Marrying a socially prominent person helps the accomplished narcissist via boastful sharing (in essence, stealing) of the partner's talents and achievements. Marrying someone far beneath one's socioeconomic status can, paradoxically, also facilitate the stabilization of narcissistic grandiosity; one can constantly demonstrate one's superiority. Besides, one can also satisfy the covert masochism, which frequently accompanies narcissism.³¹ In such narcissistic marriages, "the partner is really a servant or a convenient fixture, and depreciation and resentment are institutionalized in chronic aggressive behavior."¹¹ Clearly, masochistic tendencies on the partner's part secretly collude in the stability of such pathological marriages.

Third, marriage does not only bring a spouse in one's life but also his or her family. Cultivating and maintaining a receptive attitude towards the in-laws requires tact, resilience, and, ultimately, a deep sense of respect for the spouse's

internal objects. The narcissistic individual lacks these qualities and thus ends up alienating the spouse.

Fourth, narcissistic personalities might damage their marriages by having extramarital affairs. Such damage might remain contained within the marital bond, if it is a one-time occurrence, if the spouse has reasons and ability to be forgiving, and if the narcissistic individual himself shows the capacity for remorse. Otherwise the damage is severe enough to result in divorce. This is especially the case with narcissistic men who are habitual philanderers and whose spouses have psychically grown and become more self-respecting over time. Occasionally, however, one comes across narcissistic men who, over the course of a long marriage, begin to recognize their wife's value to them. They then make reparative gestures and might advance toward genuine concern and even love for the spouse.

The onset of middle age also poses special risks for the sexual and marital lives of narcissistic individuals. The unmarried philanderer finds his diminishing sexual prowess extremely disconcerting. It threatens to de-link him with the sole avenue he has had available for connecting with women (mother-substitutes) and drawing sustenance from them. His ever present subterranean inconsolability now bubbles to the surface. For the married narcissist, too, matters are not simple. Generally speaking, the inevitable diminution of sexuality during middle age is compensated by deepening of mutual regard, respect, and affection. For narcissistic individuals, especially men, the diminution of sexual excitement is, however, accompanied by a loss of interest in the partner. "Here, eternally youthful bodies are needed compulsively, regardless of the face, the person, and the attitudes with which such bodies relate to the (narcissistic individual)."¹¹ Hunger and greed of such proportions end up cannibalizing whatever emotional good-

ness does exist in the marriage. Further destructiveness arises from the unresolved, unconscious envy of the oedipal couple and insofar as "the narcissist's own marriage becomes unconsciously a replica of the oedipal couple, it must be destroyed." The end result is divorce, followed by a life of sexual inconsolability and spiritual desolation that can lead to suicide. Louis Begley's³² dark novel "The Man Who Was Late" offers a poignant description of such a situation. In other cases, however, the image of a lonely and rejected man becomes a "new nucleus around, which, through an old pattern, the subjective experience of grandiosity organizes itself again."³³ The debauch cleverly transforms himself into a tragic hero.

CONCLUSION

Excessive narcissism has a powerful deleterious impact upon an individual's love life. I have categorized the resulting phenomena as pertaining to romantic love, sexuality, and the marital relationship. In all three realms, narcissistic individuals manifest behavioral rough edges and subjective distress. They have impaired capacities for sustained affection and sensuality. They also frequently make marital object choices that instead of ameliorating their pathology further consolidate their grandiose and self-centered defensive stance. The ordinary, admiration-seeking narcissist shows more problems in young adulthood and the shy narcissist during midlife; the malignant narcissist^{34,35} has more sadomasochistic elements in his love life than either of the other two types. Not surprisingly, the distress of these individuals seeps into the soul of their partners who seek help with depressive symptoms and impotent rage.

Narcissistic men and women differ in the surface manifestations of their troubled love lives. Narcissistic men display sexual promiscuity coupled with a pronounced lack of tenderness, reciprocity, and affection in the context of sexual relations. Narcissistic women find it difficult to renounce

autonomy in order to enter marriage. Some of them “gravitate from one famous man to another”⁸ since their desire for an ideal man is coupled with an equally intense tendency to compete with and devalue their partner. Both narcissistic men and women fail to simultaneously maintain self-concern and object-relatedness²¹ in the realm of affection and sensuality.

Cultural factors also play a pathoplastic role in the phenomenology under consideration. For instance, in instinctually repressed societies with few rights for women, marriages of narcissistically dominant and sadistic men remain “stable” over time. Parallel avenues for extramarital sex, usually with socially inferior partners, are tolerated. When such couples migrate to countries where sexual mores are relaxed and where women find avenues for self-expression, they end up having a divorce. Breakthrough of sequestered homosexual tendencies in such immigrant narcissistic men is also not infrequent.³⁶ On the positive side, such cultures, where arranged marriages are the norm, might help a narcissistic individual marry a much healthier partner who, over time, might help ameliorate their psychopathology to a certain extent. In contrast to such scenarios, the sexually relaxed societies in the West unwittingly facilitate postponement of marriage by narcissistic individuals; this is because ample non-marital sexual outlets are available and there is less familial pressure for getting married.

In summary, the ultimate clinical picture resulting from the impact of pathological narcissism upon love life depends upon the degree of overall psychopathology, the gender of the narcissistic individual, and the cultural context in which such love relations are established and carried on. Of course, there is the ever present, additional variable of serendipity. Random external events can at times spur internal development in unexpectedly positive and negative ways. The

narcissist, regardless of his belief to the contrary, is no exception to this rule.

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