

The Dynamics and Dangers of Entitlement

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Excessive entitlement can accompany a range of other problems presented by patients encountered in psychotherapy. In its problematic form it is conceptualized here as having roots in emotional deprivation in childhood, especially when the child was used as a narcissistic extension by parents. This “special” role becomes a learned attitude and behavior and a refuge and defense against the hurt, shame, and fear resulting from this experience. Anger and vindictiveness provoked by this coercion and deprivation can reach dangerous, murderous proportions, with defensive entitlement demanding redress and revenge. A journalistic account illustrative of these unfortunate consequences is provided and interpreted. Psychodynamic treatment of excessive entitlement in an obsessive–compulsive patient, using an object relations approach, is described.

What’s troubling to us is not the campaigns’ fighting to win so much as the certainty—in both camps—that they are entitled to victory. . . . each candidate appears to be sure that he is entitled to the presidency.

—*Washington Post* editorial on the contested results of the presidential election of 2000, November 27, 2000

It has been remarked that narcissistic problems are increasingly prevalent in recent times, compared to Freud’s day when patients presented with

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more psychoneurotic problems (Kris, 1976). This has been related to an excess of competitive individualism in American culture, in which freedom from family ties and institutional constraints leads to feelings of insecurity, which are coped with by preoccupation with the self and seeking the attention of others (Lasch, 1979). These preoccupations are closely allied to the fantasy of entitlement. Ordinarily, when a person feels deprived in some way, particularly when needs are not met, he or she may well feel irritated or resentful and seek reparation. When the attitude is chronic and excessive, however, the person may bring to numerous situations the sense that he or she should be accorded special dispensation. Sometimes this insistence on redress can be vindictive and destructive, inside psychotherapy and out.

Definition and Types

Freud (1916/1957) originally discussed this attitude in regard to patients who did not want to suffer in treatment, which entailed giving up the pleasure for the reality principle. They considered themselves “exceptions” who had renounced and suffered enough and should thus be exempt from any further “disagreeable necessity” (Freud, 1916/1957, p. 320). In general, psychological entitlement may be described as “those rights which one feels justified in bestowing upon oneself” (Meyer, 1991, p. 223). In problematic entitlement the person believes that he or she has the right to special privileges due to having endured some unusual, unjust suffering. Freud (1916/1957) traced this attitude to a “common peculiarity”: viewing a painful event or experience in early childhood as an unjust injury (p. 320). In indignation the person rebels against the injustice and feels justified in claiming compensatory privileges. The author cited two cases in which this “painful experience” was a congenital or physical illness of the patient as a child. Freud implied that perceived emotional injuries could also be the basis for this rebellion.

Later theorists distinguished between normal, excessive, and restricted (or inhibited) attitudes of entitlement (Kriegman, 1983; Levin, 1970; Moses & Moses-Hrushovski, 1990). In the “normal” type, a person has an appropriate, reality-based assessment of the compensation to which he or she is entitled for a disappointment. In contrast, in the “excessive” mode, the person exhibits self-righteousness, grandiosity, and demandingness. At the opposite extreme, in the “inhibited” mode or underentitlement, the person underestimates what is his or her due.

Healthy entitlement can be distinguished from the excessive variety in various ways. In children, the demandingness of normal infantile narcissism is related to real needs, while that of pathological narcissism is “excessive, cannot ever be fulfilled, and regularly reveals itself to be secondary to a process of internal destruction of the supplies received” (Kernberg, 1986b, p. 254). In normal entitlement the child’s need to be the center of attention and admiration coexists with the capacity for genuine love, trust, and dependence on others. In contrast, persons with excessive entitlement often seem to have difficulty trusting and empathizing, instead devaluing others when not temporarily idealizing them as potential sources of narcissistic supplies.

Etiology, Dynamics, and Defense

Excessive entitlement arises in consequence to depriving childhood experiences with parenting figures. When these experiences are chronic and repeated they may cumulatively be felt as traumatic (Shabad, 1993). Children have a legitimate need, that is, an appropriate entitlement, to be paid attention to, understood, and respected by their parents (Miller, 1986). Kris (1976) described these needs as “passive libidinal wishes” to be taken care of, loved, and admired (p. 85). He explained that when satisfaction of these wishes is blocked, when the individual feels that he or she is not loved enough, there appears a “compensatory increase” in “active libidinal wishes,” that is, demands for love, care, and comfort (Kris, 1976, p. 85). Passive wishes are transformed into active ones.

Years later, Shabad (1993) described a similar process when frustrated wishes are transformed by the child into entitled “needs.” When a child feels excessively frustrated by the parent and helpless to change the parent into the wished-for figure, he or she defensively shifts from this helplessness to “identification with the aggressor.” The child identifies with the internalized object that “crushes his or her wishes,” thus recreating in him or herself the original injury in an attempt to master the traumatic experience (Shabad, 1993, p. 484). However, in resentment and indignation at this injury, the individual seeks to revive these important wishes by transforming them into demands or “needs” that must be fulfilled. The “need” becomes an insistence that one be compensated for deprivation. Thus, this attitude of entitlement defends against feelings of powerlessness and helplessness. In normal development a feeling of power emerges when the child realizes the “basic entitlement to feel accepted and

appreciated” on his or her own terms (Billow, 1999, p. 474). When “normal requirements to feel special and be affirmed as powerful” are not met, pathological entitlement may develop (p. 474).

Unresolved Omnipotence

Some of the dynamics of entitlement can be explained developmentally in terms of unresolved childhood omnipotence. A healthy sense of self develops if the child can use the mother to obtain appropriate mirroring and empathy, for normal narcissistic development (Miller, 1986). In this process, the child cathects the mother narcissistically as part of him- or herself to internalize that approving, idealized selfobject (Kohut, 1971). The mother must allow herself to be used in this way. When the child can freely and spontaneously express emotions and impulses without fear of rejection, his or her sense of self is strengthened.

On the other hand, when the mother is not able to provide this narcissistic function for the child, and, on the contrary, needs narcissistic supplies herself, the child’s normal, controlling omnipotence is disturbed (Miller, 1986). The mother uses the child as a “part object,” or narcissistic extension, for her own gratification. She may love her child passionately as her own selfobject, but this love is not for the child’s “true self.” The child develops something the mother needs, which ensures his or her survival, but true emotions and impulses may be split off and sacrificed as a result. A child in this situation is under great pressure to conform his or her responses and feelings to the necessity of preserving a secure relationship with the parental figure (Coen, 1988). However, being forced into the role of narcissistic extension, a “false self,” is a type of coercion that the child naturally resents. This anger provides some of the impetus for the development of entitlement.

This exploitation of the child serves the purpose of helping the parent avoid his or her own internal conflicts (Novick & Novick, 1991). Disavowed feelings are projected onto the child, disregarding the latter’s autonomy and identity. As the child accepts this depriving arrangement he or she may feel the promise of a magical, omnipotent relationship with the parent. This inclusion of the child into the narcissistic world of the parent encourages a sense of specialness in the child. However, the promise of specialness is severely frustrated by the parent’s true unavailability.

For example, Kernberg (1986a) noted that entitled patients often occupied a “pivotal point” in their family structure, such as being the only child, the only “brilliant” child, or the one who is supposed to fulfill the family aspirations (p. 220). Similarly, a child’s overinvolvement with a

parent of the opposite sex can lead to a sense of oedipal victory (Lane, 1995). Although at one level this overgratification makes the child feel special, this indulgence is not the same as attunement, for which the child is being deprived. In this way, parental overinvolvement impedes the child from being appropriately weaned from the normal omnipotent position, with the result that he or she remains dependent on the mother for the sense of self (Rothstein, 1977). Underlying this overvaluation of the child, however, is a lack of true relatedness, which is felt as a narcissistic injury. Therefore, the sense of specialness, and its concomitant, entitlement, may become a refuge for coping with the hurt feelings related to this injury.

Entitlement as a Defense

Narcissistic entitlement represents more than just an attitude and behavior learned from caregivers who taught the child to feel special for the emotional services he or she provides. Freud believed that, for such individuals, the deprivations of childhood led to their withdrawing libido from people and the external world and directing it to the self, as a defense (Freud, 1914/1986). Similarly, Kernberg (1986a, 1986b) believes that the nature of these patients' object relations impels them to erect "omnipotent" defenses. In this view, the relationship with caregivers who chronically behave with "callousness, indifference and nonverbalized, spiteful aggression" (Kernberg, 1986a, p. 220) leads to the failure in the child to integrate idealized object images into the superego, as the real object images are so harsh and critical. Instead, the ideal object and self-images are "condensed . . . with the self-concept" (Kernberg, 1986b, p. 263). This bolstering of the self shields the individual from painful feelings associated with the loss of the ideal object. One byproduct of such poor superego integration may be the failure to internalize a value system patterned after the parents.

In these circumstances the sense of self is precariously based upon rigid idealizations of self and other. In other words, without clearly differentiated self and object representations, the original, normal omnipotence is not resolved. In this omnipotence, the individual experiences all objects as part of or as controlled by him- or herself (Morgan, 1985). This unresolved omnipotence comes to serve a defensive function to cope with helpless envy and rage provoked by the experience of feeling unloved and exploited (Kernberg, 1986a). The anger may be projected out, resulting in paranoid fears of attack and destruction, or it may be directed as criticism toward the self. Such self-condemnation leads to feelings of defectiveness and shame. In terms of object relations, the critical, demanding parent is

internalized as a harsh superego, by which the individual comes to “deprive” him- or herself. As noted earlier in Shabad (1993), the person identifies with the aggressor, who “crushes her wishes.” Defense is needed against this internalized threat that impoverishes through fear and shame. Such efforts take the form of grandiosity, fantasies of power and greatness, and the devaluation of others, a defense, which in fact is modeled after the self-centered parent (Kernberg, 1986a). However, this provides some measure of self-esteem for the person. If a person suspects that he or she is the “worst,” the person has to be the “best” to have any value (Brand, 1968). Entitlement is a concomitant to such self-inflation. Intense rage is accompanied by demands for compensation, a demandingness that the individual saw in his or her own parent. In summary, empathic failures and the failure to achieve fulfilling interactions with significant others “forces the child to turn to omnipotent solutions,” one of which is pathological entitlement (Novick & Novick, 1991, p. 411).

Coen (1992) believes that the most malignant forms of entitlement occur when patients feel they have been misused and exploited by parents, occasioning a feeling of having suffered unjustly. Fueled by resentment, these patients feel they can take what they want from others, in a reversal of the original exploitative parent-child relationship. This anger and demandingness interfere with the ability to empathize with the needs and rights of others. For Grey (1987), more severe cases of pathological entitlement are associated with the wish to humiliate and destroy, which enhances a sense of power and mitigates underlying feelings of helplessness. According to Lane (1995), the wish for revenge has its roots in early mismatches between the mother and infant, wherein the caretaker fails to respond to the infant's cues. As a result, discomfort is not replaced with comfort, needs are not met, and the child becomes more and more frustrated, enraged, and vengeful. From a sense of injustice and a need for reparation, the individual seeks to triumph and beat the system. Envious of others due to perceived deprivation, these individuals wish to steal the possessions, beauty, reputation, and accomplishments of others, or to spoil these things.

In vindictiveness the individual may seek to attack and destroy an important object in order to eliminate a source of love and gratification that is envied and feared (Kernberg, 1986b). For Morgan (1985), this destructiveness is a defense against the painful “knowledge of the need for love” from a disappointing source. Awareness of envy needs to be warded off, as this would be an acknowledgment that the object was a source of gratification and not a part of the person him- or herself. One way to avoid

such awareness is “absolute destruction of the other,” except as something to have control over:

The more this knowledge has to be destroyed, the more the other has to be enslaved, marginalized, and in the final scenario, killed. . . . As one object dies another can be used to replace it . . . [reflecting the patient’s] own experience of negligence at the hands of others. (Morgan, 1985, pp. 139–140)

In terms of object relations, the shameful, unwanted, split-off aspects of the person are projected onto the other, justifying devaluation or annihilation of them, with the patient feeling some relief from his or her own fears of annihilation.

These narcissistic defenses are seen in varying intensities across different types of character pathology. The attitude of entitlement is found in patients who present with a variety of other problems. In patients who lack the narcissistic personality structure the resentment and anger toward important objects is temporary and does not eventuate in massive devaluation (Kernberg, 1986b). In nonnarcissistic patients, entitled demands in times of anger are seen to alternate with expressions of love and gratitude and the capacity for dependence upon others, while narcissistic persons, however, may show little separation anxiety or mourning when relationships are terminated.

Case Vignette

The following vignette¹ illustrates how an experience of deprivation and entitlement led to murder. A student was reprimanded and disciplined at middle school, and this seems to have reactivated old narcissistic injuries, with the individual feeling unable to bear intense emotions of shame. In the end this seems to have resulted in the acting out of murderous and entitled feelings upon an important object. Early deprivation in this case took the form of both father absence and exploitation by the mother as a narcissistic extension of herself.

Recently in our community a 14-year-old adolescent was convicted of second-degree murder for shooting to death his English teacher. Journalistic depictions of the boy’s family life and events leading up to the murder suggest the development of an attitude of entitlement in the perpetrator which may have played a part in these events. In journalist ac-

¹This case presentation and conceptualization constitutes the opinions of the authors and does not necessarily reflect the point of view of the editors or the publisher.

counts the mother described her son in adoring, idealized tones. As a toddler he was reportedly very intelligent: "my little sponge" who soaked up knowledge prodigiously (Norman, 2000, p. 18). She indicated that she was determined to nurture his mind: "My son has a brain, and he was going to use it" (p. 18). She seemed to consider him more than just a child: He was her "little man," too (p. 18). She believed that her child had "something great" and that with the proper guidance the world would recognize this, and that he would accomplish great things (p. 18). The mother reportedly hoped that the boy would raise the reputation and esteem of the family, the ancestors of which had been slaves in South Carolina.

The mother, an aide in a nursing home, separated from the boy's father soon after his birth. She later married another man, but after physical and emotional abuse in that relationship, they divorced. She has since remarried, and the family is living with her current husband. Despite her limited income the mother reportedly always bought expensive toys and appliances for her son. The boy had a reputation for being quiet and fairly studious. In the past year, however, he had reportedly been watching more violent, militaristic films and video games on the television set in his room, as well as visiting military sites on the Internet at his computer.

As reported in the newspaper, the student had recently been rejected by a girl he liked at school, whereupon he chewed and swallowed packs of gum every day for a month in hopes that this would harm his stomach and cause him to die. This rejection seems to have been seriously distressful for him, suggestive of a vulnerable sense of self.

Another incident this year suggests an attitude of excessive entitlement. According to a teacher, the boy and another student got into an argument in class over a bottle of fruit juice. The teacher took the bottle away from them. The boy stood up and "glared" at the teacher, saying, "Give me back my drink." The following is the teacher's account of what happened next:

He said it again, only louder and in a real threatening tone: "Give me back my drink!" And he kept saying it, "Give me back my drink." It was like he was demanding it back. I was wondering what he was going to do. It was like, And if I don't? What was he going to do? (Norman, 2000, p. 19)

Later the boy returned to the teacher's classroom and took all the extra pens and pencils the teacher kept in a cup on his desk. When the teacher asked what he was doing, the student replied, "You took my drink, so I'll take your pencils."

Finally, to recount the crime for which the student has been convicted, on the last day of school many of the students had brought water balloons, which had been banned, and were throwing them. The boy was caught doing this by the guidance counselor and was suspended. According to witnesses, he was noticeably frustrated about the suspension. One of his friends who was also caught described the boy's feelings to a journalist: "[He] couldn't believe he got suspended. All those other people didn't get in trouble. Just us." Later, the adolescent returned to the school with a handgun. He went to the classroom of his English teacher, who he reportedly liked very much, and asked to speak to two of his friends. When the teacher refused his request, the student pulled out the gun, pointed it at the teacher's head, and shot him.

Although information about this case is limited, it is possible to surmise how this awful incident came to pass. To look into his history, it appears that the student may have been overinvolved with his mother and treated by her as a narcissistic extension, the only "brilliant" child, the one who would fulfill the family's aspirations for recognition and esteem. In this role the boy was idealized by the mother and treated as special, when, for example, she showered him with expensive toys and games. In this way the child's identity was defined by the mother for her own purposes. If the child experienced a lack of maternal attunement to his real self, developing an excessively false self, he may not have been sufficiently weaned from the infantile omnipotent position. The deprivation inherent in this situation may have led to his turning to his "specialness" as a refuge and defense against painful feelings of injury. Also, deprivation may have been felt in the lack of a consistent father figure in his home life.

This adolescent reacted to disappointment and perceived deprivation at school with extreme distress and anger. When the boy felt rejected by a girl, he turned his anger destructively upon himself. When he felt deprived of his fruit juice, he responded with intense rage, demanding its return, and when refused, took other items in recompense, as though he were entitled to them. Finally, when he felt unfairly punished for breaking a rule in school, this was experienced as such an injury that his rage and entitlement demanded restitution in the form of punishing the authority figures who he believed had wronged him. In this attack the "powerless" boy is attaining recompense from a transference object who embodies the hated, coercive, depriving parental image.

In expressing his rage, however, he does so in the only way he knows how, the way he had learned from a parent who had crushed his wishes. His harsh superego acted out this scenario externally, crushing the

teacher, upon whom the child had projected unwanted aspects of himself, thereby devaluing the person and justifying his destruction. As a result of superego difficulties, it seems that the boy had failed to develop an adequate value system that could have militated against the act of murder. In other words, the adolescent took the part of the internalized parent who only thought about his or her own needs. As such, the boy cared only about what he wanted, sacrificing the rights and autonomy of the teacher. In this act of vengeance the adolescent sought to quell painful feelings of shame, envy, and rage. It seems that he felt entitled to beat the system. In summary, the boy's suspension from school seems to have reactivated internal object relations and corresponding emotional pain related to early deprivation. It appears that he turned to an omnipotent solution to what he felt was an injurious, empathic failure.

Treatment of Entitlement

Transference

In treatment, narcissistic entitlement is seen in the transference. According to Lerner and Lerner (1996), the therapist is often perceived in two completely different ways, which may alternate in the same patient. For Kernberg (1986a) these two roles derive from the splitting of the object representation of the parent into the neglectful, exploitative object and the ideal, loving object. Fairbairn (1952) has described how this splitting occurs in the infant who feels intolerable frustration in his or her object relations. The infant takes in the experience of the mother as rejecting but discards this image by splitting it off from the image of the ideal mother and pushing it out of consciousness. Likewise the self-representation is split into those parts that are attached to the corresponding aspects of the maternal object, with the feelings attendant upon that interaction. Thus, when the therapist is seen as the abandoning, cruel parent, he or she is angrily accused of maltreatment and injustice (Lerner & Lerner, 1996). In other words, when the rejecting object is projected onto the therapist, the patient feels the fear and anger of the rejected portion of the self-representation. The activation of these internal images and feelings leads to entitlement: demands for reparation and special consideration due to misdeeds of the past perpetrated on the patient.

On the other hand, when the therapist is seen as the ideal object, then the yearning, longing portion of the self representation looks to the therapist to provide what was missing in childhood: perfect empathic attune-

ment, full emotional availability, and unlimited generosity (Lerner & Lerner, 1996). When the parent has made an implied “promise” of indulgence, in return for exploitation, as proposed by Coen (1992), the therapist is expected to fulfill that old promise. The patient is striving to enact fantasies of reunion, treating the therapist as a part object who can gratify the entitled one’s urgent expectations (Billow, 1997).

These two alternating projections, which both involve entitlement, have further implications for the patient’s transference. When the abandoning object is projected onto the therapist, the patient’s corresponding feelings of fear and hatred prevent the patient from allowing him- or herself to trust and depend on the therapist, as it is reminiscent of painful childhood experiences with dependency (Kernberg, 1986a; Lane, 1995). Similarly, the patient may have difficulty tolerating his or her own improvement in the therapy, as this is acknowledgment that he or she is being helped and thus, in some way, of being dependent. These patients can actively “take,” but passively “being given to” is more difficult (Kris, 1976, p. 88). Therefore, the individual may attempt to defeat the therapist and the therapy, to sabotage and “murder” what is helpful in it, a phenomenon known as the “negative therapeutic reaction” (Lane, 1995). When these dynamics are in play, traditional interpretations, particularly directed toward resistance, may be experienced as criticism by a parental figure, as a failure to appreciate and value him or her for who they are (Lane, 1995; Bromberg, 1986). In short, the intervention may be seen as a sign of the therapist–mother’s narcissism.

Conversely, in a reversal of this same projection, when the patient identifies with the narcissistic, entitled parent and projects his or her devalued self representation, the therapist becomes an audience, a narcissistic extension to be used for the patient’s gratification. Grandiose and aloof, the patient seeks to triumph over the therapist, as the patient’s parent triumphed over him or her (Chasseguet-Smirgel, 1988). The person attempts to humiliate the therapist as he or she has felt humiliated, make the therapist feel as inferior as they have felt, and control the analysis as they have felt controlled (Lane, 1995). These unconscious maneuvers may make it difficult, however, for the patient to work in the transference, reporting ongoing thoughts and feelings.

Countertransference

This harsh treatment of the therapist, as the patient alternates between suspicion and grandiosity, either of which may feel devaluing for the therapist, is difficult to endure. However, it is useful to note that the

therapist's countertransference feelings are close to the patient's own, particularly as the patient experiences less independence from the therapist due to the poor differentiation of object relations. In these countertransference feelings the therapist is privy to how the patient feels, information which aids in providing empathy.

The patient's anger over original narcissistic injuries, including coercion, exploitation, and deprivation, may extend to vindictiveness and the wish for revenge (Lane, 1995). The patient may become provocative, inciting the therapist into an error in order to have an excuse for displaying hostility. The patient may seek to "steal" from the therapist in some way, as entitled reparation for what was rightfully his or hers in the first place. Patients may even be willing to hurt or destroy themselves to get back at the therapist (Lane & Chazan, 1990). The patient's envy, anger, and greed, from the perception of having been unfairly deprived and coerced as a child, must be understood and contained by the therapist.

Brenman (1985) has suggested that the therapist has to "tolerate being the victim of cruelty," including accusations, name-calling, fantasies of violence, and the patient's need to be in control all the time; otherwise, battles with the patient will ensue. The patient demands more and more, yet is acutely aware of the therapist's shortcomings and errors, ignoring the helpfulness. The therapist may experience countertransference feelings of being trapped, guilty, and helpless. To endure this requires much understanding and tolerance in the therapist (Langs, 1976). However, in providing acceptance of the patient's disappointment and pain, and the resulting anger and vindictiveness, the patient is accorded an experience of empathy heretofore unknown. This containment permits the defusing and integration of these negative feelings.

Working in the Transference

According to Bromberg (1986), for psychotherapy to help the person "grow" beyond where he or she is "stuck" emotionally and interpersonally, it must provide an environment that allows the person to experience him- or herself in a new way (p. 462). It must provide an environment that facilitates the acceptance and integration of "unpleasant but accurate" experiences of the self that are usually avoided (p. 462). Thus, for patients who utilize omnipotence and entitlement, it may be most effective to precede any analysis and interpretation with a period of empathic trust-building (Brenman, 1985; Bromberg, 1986; Kohut, 1971). The fantasy of entitlement serves a protective and defensive function that in the beginning of therapy needs to be respected and preserved, as the grandiose self

is the one structure the patient depends upon for identity (Bromberg, 1986). Grandiose invulnerability protects the patient from excessive anxiety due to impinging, unempathic objects. This protection ought not be undone until the patient adequately trusts the therapist. At this point in the therapy, for the patient to allow awareness and critical appraisal of the grandiose self may risk losing that defense, which is intolerable. When the therapist provides the empathic mirroring that the person was entitled to as a child, he or she can acquire the "security of positive feeling" which permits self-observation. These experiences in therapy are restitutive in that they address the ego's earlier, basic needs for affirmation.

Helping the patient to be able to eventually work in the transference is a slow and gradual process (Bromberg, 1986). Throughout treatment the therapist attempts to strike the proper balance between empathizing, on the one hand, and allowing the patient to experience anxiety, on the other. Early in therapy the balance is weighted toward providing more empathy, helping the patient to feel understood. When the therapist "mirrors," he or she attempts, in a caring stance, to accurately reflect the patient's feelings or experience. These attempts communicate understanding and validation of that experience, a function which promotes safety as well as self-acceptance in the patient.

Later, the patient is provided increased confrontation when he or she can tolerate the anxiety. Initial interpretations, for example, may validate the patient's need for the existing self and object structure. The patient may be reassured that his or her current defensive structure once played an appropriate role and that it is needed for protection from the relationship with bad objects (Kohut, 1971). Similarly, Kernberg (1986b) has cautioned against confrontation and taking a moralistic attitude toward the patient's grandiosity. This approach introduces the patient to his or her character structure as a functional part of the personality, not as an illness for which the person is being blamed.

In a subsequent type of intervention, the therapist encourages the patient to report the small details of specific, external interactions with others that have proved to be problematic (Bromberg, 1986). This type of interpretation accustoms the patient to looking at him- or herself from the outside, developing the observing ego. Through the provision of mirroring and understanding of discomfort, the patient gradually becomes more able to risk awareness of behavior.

According to this treatment scenario, as the patient feels increasing safety, his or her "regressive experience deepens," (Bromberg, 1986, p. 460), with the emergence of entitled yearnings and demands. Gradually,

the therapist becomes more confrontational, with anxiety for the patient starting to outweigh empathy from the therapist. The patient is encouraged to focus his or her newly developing observing ego on the transference. As the patient internalizes the therapist's mirroring and soothing operations, which build new ego functions, he or she is able to tolerate working in the transference.

As genuine affects of fear, shame, and rage emerge, the therapist provides more confrontive interpretation of the patient's behavior and dynamics (Bromberg, 1986). Such interpretation can include helping the patient understand how devaluation of the therapist is an aspect of defense against intense, overwhelming feelings of shame and rage. This anger and aggression in the transference may cause the patient to fear his or her own destructiveness, and hence, retaliation from the therapist (Kernberg, 1986b). The person may fear that he or she will destroy the relationship that they desperately need and ruin their hope of being helped. Here, the therapist's own internal security and equanimity can reassure and contain these fears. Neglecting to analyze these negative aspects of the transference may increase the patient's fear of his or her destructiveness, which may occasion withdrawal (Kernberg, 1986b). Such interpretive efforts, however, must continue to be couched in an environment of empathy and attunement. Otherwise, interpretations may be experienced as critical evaluations by a narcissistic parent. Although the patient may well continue to seek to psychologically destroy any goodness proffered by the therapist's mirroring or resist allowing him- or herself to be affirmed, these efforts too can be empathized with and validated. Over time, this stance by the therapist helps the patient feel cared about, respected, and understood, which builds the safety required for tolerating and understanding interpretation.

Castelnuovo-Tedesco (1974) emphasized the need to focus on the patient's envy and greed, helping the patient to understand how the perception of having suffered cruel injustice impels him or her to seek reparation. This involves working through the omnipotent defenses against awareness of the injurious object that the patient has idealized (Lane & Chazan, 1990). The therapist can help the patient make the connection between parental failures, narcissistic injuries, and current and past acting out (Lane, 1995). In some of these interpretations the patient will feel confronted and become enraged. However, in the safety and containment of the therapeutic bond, and due to the developing capacity to feel another person as being separate, along with seeing him- or herself more objectively, the patient's rage can "support the individuation process" and be-

come gradually integrated as healthy assertiveness and self-regard (Bromberg, 1986, p. 460).

One of the principal goals of therapy is to help the person re-experience these genuine affects, which are part of the true self (Miller, 1986). As the false self was developed by the child, as he or she was pressed into service by the mother for her own narcissistic needs, the true self of the patient was suppressed, occasioning depression, which often brings the patient into therapy. When these rejected, painful affects, usually warded off with omnipotent entitlement, break through and are experienced in the transference, the patient is helped to gain insight into early object relationships. The patient is no longer forced to suppress painful feelings, as with the false self, but can experience them, which is a form of mastery and integration.

When these genuine feelings emerge, the patient is better able to understand the rigid idealization of self and parents (Miller, 1986). As the dynamics in the transference become better understood, the patient can begin to effect an integration between split-off parts, realizing that the hated therapist–mother and the idealized, longed-for therapist–mother are really the same individual (Kernberg, 1986a). With understanding and working through of these dynamics and object relations, the patient's mental structures mature, bringing increasing differentiation of self and object representations, which aids individuation and the ability to see the therapist as a separate person. Importantly, as he or she internalizes the soothing and understanding functions of the therapist, the patient is able to rely on this new, benevolent object relationship as a source of internal support and structure. In this way, the individual develops the capacity to self-empathize. In this way, the patient is able to mourn the "tragedy of not being loved for him or herself" (Miller, 1986, p. 342). For Miller, "only mourning what was missed . . . can lead to real healing" (p. 332).

Clinical Vignette

In this case the treatment of an obsessive patient was complicated by his defensive entitlement. "Mark" is a 43-year-old, single, elementary school teacher who was seen twice a week for 2 years in psychoanalytic psychotherapy. He began therapy with complaints of emotional constriction, depression, and social isolation. As a child his parents reportedly often ignored him and left him alone, especially when he became upset. The patient described this experience as extremely hurtful and wounding. The

parents divorced when Mark was 7, whereupon he rarely saw his father and came to feel responsible for taking care of his mother, with whom he currently lives. As a result of the parental neglect and the feeling of responsibility for his mother, the patient reported overwhelming feelings of rage which he was afraid of revealing, for fear that these feelings would either be ignored or get out of control.

Over the 2 years the patient was treated with consistent, protective mirroring to provide him with the safety and containment necessary for increased awareness and tolerance of his feelings of hurt and anger and the narcissistic defenses against them, including entitlement. In the transference Mark played out various self and object representations. Often he refused to describe or express his thoughts or feelings for fear that he would be judged harshly by the therapist, or that the therapist would minimize, belittle, or ignore what he expressed. Here he was projecting onto the therapist the image of the neglectful, rejecting object. This activated corresponding feelings in his self-representation of distrust, fear, and shame. He obsessively disputed what the therapist had to say, often quibbling over semantics. In his distrust he would report feeling increasing frustration and anger.

Other times, these projections were reversed, and Mark assumed the role of the critical, unempathic parent figure. In most sessions, he expressed some form of criticism, complaint, sarcasm, or devaluation of the therapist. In the countertransference the therapist felt he was constantly being evaluated and punished. He felt trapped, controlled, frustrated, guilty, and angry. The patient had projected the devalued aspects of himself onto the therapist, letting the therapist know how he had felt as a child at the hands of frustrating, rejecting parents.

Alternately, when the patient projected the idealized object onto the therapist he expected perfect empathic attunement and more availability and generosity. For example, he expected the therapist to sense what he was feeling and experiencing without his having to tell him verbally. When the therapist erred in his understanding, the patient expressed frustration, irritation, and anger. When sessions ended at 50 minutes the patient was visibly disappointed and irritated, asked for more time, and was slow to leave. On two occasions he requested that sessions be lengthened to 90 minutes as he said he needed more time to feel comfortable enough to express himself. When the request was denied he felt hurt and angry.

In providing mirroring the therapist reflected back the feelings that he detected in Mark. He attempted to fathom empathically what the patient was experiencing and communicate his understanding and appreciation of

that. In light of Mark's hypersensitivity to nonattunement and his tendency to obsessively dispute, the therapist attempted to reflect and empathize as accurately as possible. Yet the patient often complained that he was not being understood. Here, it was necessary to help Mark become aware of the anger in his criticism, that his fault-finding was an expression of anger. It was suggested to him that his demand for perfect attunement was an indication of how much he needed that, having been deprived of it in childhood. The therapist apologetically took responsibility for missing the mark, for not giving him what he should have gotten. This was intended to let the patient know that he deserved to be understood and have his feelings validated. When Mark demanded longer sessions, however, the therapist decided to maintain the therapeutic frame and replied to him that he understood how he felt he needed more time, but that the therapist wanted to encourage him to try and express himself in the allotted time. His desire for more time was then explored further and understood as his needing "more" from the therapist due to feeling deprived.

This therapy emphasized the provision of empathy, and in this containment the patient was observed to allow himself to regress into mute, bodily expressions of anxiety and anger. His inner struggle was observed in his bodily tension, grimacing, twitching of his limbs, rapid bouncing of his legs, and occasional punching into the air. As the therapist empathized with his evident emotion, Mark would verbalize his fears of judgment and abandonment. Over time these concerns and expectations were explored to ascertain the components of his self and object representations. By 1 year and 6 months of therapy, the patient had begun to put more and more of his feelings into words. Interpretations were minimal as the patient tended to use them as opportunities for disputation and intellectualizing. Unfortunately, as Mark became more comfortable expressing his feelings verbally, his fault-finding of the therapist increased. He finally declared that he could not "trust" the therapist to give him what he needed, referring to his being denied the lengthier sessions and to two cancellations due to therapist illness. He said that recently he found himself upset and angry before, during, and after sessions, and that he could not tolerate this state of affairs. He requested to be transferred to another therapist in the clinic. After much discussion, to support the patient's self-direction and autonomy, this change was effected.

In retrospect this therapist regrets not interpreting more extensively to Mark the possible meanings of his negative transference reaction and entitlement, especially the connection between deprivation and anger. As the patient's unacceptable feelings were being revealed more and more, he

evidently was feeling greater anxiety also. In terminating with this therapist he may have felt the need to distance himself from uncomfortable dependency or intimacy, or simply the intensity of anger and its possible consequences. If anxiety from a perceived threat of abandonment was intensifying, he may have felt the need to take matters into his own hands and leave the therapist. The patient's distrust finally took the form of increased devaluation of the therapist and defeat of the therapy. Although the patient left therapy prematurely without learning more fully about these dynamics, on the positive side, he had achieved his stated goal in treatment of improving his ability to verbally and directly express his feelings to another person. In the safety of the therapeutic relationship his feelings had become more tolerable and acceptable to the point where he could express them openly. By the end he denied any feelings of depression and seemed to look and feel energized by his declarations of independence from the therapist.

Conclusion

The attitude of entitlement is commonly encountered in ourselves and others. All of us experience deprivations and narcissistic injuries, of varying degrees, in childhood. These prompt our indignation, conscious or unconscious, and the attitude that a wrong that was committed against us should not have happened, that we should not have to endure it again, and that we should be compensated in some way. However, when such an attitude pervades a person's mental life and dictates how they govern their interpersonal encounters and relationships, then more severe childhood emotional deprivation or impoverishment is suggested.

One type of deprivation especially conducive to the development of a sense of entitlement occurs in the context of being coerced into serving as a narcissistic extension for significant others, which necessitates the evolution of a false self. This coercion and deprivation may provoke intense, even murderous rage. Grandiosity and entitlement may emerge as a defense against the emotional anguish of fear, shame, and guilt. The sense of being entitled to seek vengeance can indeed have destructive consequences, including attempts by the patient to defeat therapy and the therapist, as well as violent acts, including murder.

Treatment consists of providing empathy and safety in a therapeutic relationship that permits the patient to gradually identify and understand the relevant self and object relationships and the concomitant feelings and

dynamics that inform them, as they appear within the transference and countertransference. Maturation of the object relations occurs through a process of experiencing and understanding these relations, allowing for eventual integration of unpleasant and rejected parts of the self, which result in the healing and strengthening of mental structures and ego functions.

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