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# MAINTAINING BOUNDARIES IN PSYCHOTHERAPY: COVERT NARCISSISTIC PERSONALITY CHARACTERISTICS AND PSYCHOTHERAPISTS

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*The psychological literature to date has identified more than one form of narcissism: the more well-known grandiose form, and the less familiar and recognized covert form. Although the distinction between these two narcissistic types has been identified with regard to better conceptualizing client dynamics, there has been much less written about how covert narcissistic tendencies and traits may affect psychotherapists and psychotherapy. This paper uses psychodynamic theory to highlight the role that covert narcissistic characteristics may have on the psychotherapists' ability to maintain boundaries, potentially leading to boundary transgressions (existing along a continuum from therapeutically useful to maladaptive and antitherapeutic). Specific therapeutic situations have been delineated to increase therapists' recognition and awareness of themes that may emerge and compromise the boundaries between themselves and their clients. Areas of focus include narcissism and its forms, the possible connection between covert narcissism in psychotherapists and the impact on managing boundaries, the potential therapeutic implications of covert narcissistic tendencies in psychotherapists, and the implications of covert narcissistic personality characteristics on treatment, supervision, and training.*

*Keywords:* covert narcissism, psychotherapy, boundaries, narcissism, psychotherapist

Narcissism is something that is inherent in all of us: we like to feel good about ourselves and what we accomplish, and we can also be injured by how others perceive us and respond to us (McWilliams, 1994; I. Miller, 1992; O'Brien, 1987). Narcissism generally refers to the interest of individuals in themselves (Wink, 1996). Narcissism, like other personality characteristics, exists on a continuum from healthy to unhealthy (Emmons, 1987; Gabbard, 1994; Millon, Grossman, Millon, Meagher & Ramnath, 2004; PDM Task Force, 2006; Raskin & Hall, 1981; Watson, Morris, & Miller, 1997–1998; Wink, 1991, 1996). It is not inherently unhealthy, as narcissistic strivings potentially allow us to both believe in our abilities and ourselves as well as be able to depend on others in times of stress or need (Kohut, 1971, 1984; I. Miller, 1992; Wink, 1996; Wolf, 1988). Moreover, in its healthy manifestations, narcissism has empirically (Lapsley & Aalsma, 2006; Raskin, 1980; Raskin & Hall, 1981) and conceptually (Kohut, 1966; I. Miller, 1992; Wink, 1996) been connected to adaptive characteristics such as creativity, empathy, stability, adjust-

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ment, and an orientation toward achievement. However, when narcissism is problematic and maladaptive, individuals have an inordinate investment in others' affirmation, and struggle to have a well-defined sense of who they are (I. Miller, 1992; Watson, Sawrie, Greene, & Arredondo, 2002; Wink, 1991). This may lead individuals to respond in ways that will enhance the possibility that they receive from others what they cannot find within themselves: a sense of power, purpose, acceptance and importance (I. Miller, 1992).

Although most of the focus of empirical and clinical study has been on narcissism as a unitary construct (Hendin & Cheek, 1997; O'Brien, 1987), two distinct forms of narcissism exist: a grandiose type that is exemplified by a heightened sense of self worth and a covert type that is exemplified by a devalued sense of self worth marked by timidity, inhibition and an overwhelming sense of failure rather than accomplishment. It has been postulated that the personality characteristics associated with the covert form of narcissism may be present among some psychotherapists and may contribute to highly specialized skills of empathy and attunement (Glickauf-Hughes & Mehlman, 1995; Grosch & Olsen, 1994; A. Miller, 1997; Sussman, 1992). In many ways, these characteristics potentially make individuals excellent candidates for the demands and skills needed to practice psychotherapy. As will be discussed in this article, the very same personality characteristics that pave the way for empathic attunement may also increase the difficulty of maintaining therapeutic boundaries in the relationship between therapist and client. Although there has been discussion in the literature of the existence of covert narcissistic tendencies, traits and disorders in psychotherapists (Glickauf-Hughes & Mehlman, 1995; A. Miller, 1997; Sussman, 1992), the potential for difficulty in maintaining boundaries between client and therapist as a result of these traits has not been addressed. Furthermore, the specific ways that boundaries may become compromised in psychotherapy given these personality dynamics have not been delineated. This paper will focus on the potential existence of covert narcissistic traits in psychotherapists, a discussion of specific boundary-related issues that can arise in psychotherapy as a particular function of those traits, and how they can be identified. Treatment, prevention, and training issues are discussed as well.

It is important to note as part of the introduction to this paper that what follows is a work influenced by a strong interest on the part of the authors to make a contribution that is both heavily theoretical and clinical. The authors approach this topic from a relational psychodynamic theoretical paradigm, a contemporary synthesis of self-psychology, object relations, and interpersonal views. The central foci of this theoretical perspective are relationships, including the relationship between therapist and client and the complex intersubjective dynamics that emerge as part of the therapeutic process. Because psychotherapy exists in the context of a relationship between two people, therapist awareness of potential narcissistic vulnerability is crucial as their own intrapsychic and interpersonal dynamics may influence the therapeutic work by potentially compromising therapeutic boundaries. Hopefully, this paper will offer therapists an opportunity to reflect on and increase their awareness of how their own processes influence their work, with special attention given to the many ways in which their own needs may be playing out and impacting the psychotherapeutic process.

## Two Forms of Narcissism: Unifying Convergent Theories

Two distinct forms of narcissism have been delineated empirically (Dickinson & Pincus, 2003; Hendin & Cheek, 1997; Rathvon & Holmstrom, 1996; Watson, Morris & Miller, 1997–1998; Wink, 1991) and through clinical observation based on interpersonal patterns and styles (Gabbard, 1994; Kohut, 1971, 1984; PDM Task Force, 2006; Wolf, 1988). However, each type manifests in different ways: a grandiose type that is exemplified by the devaluation of others and the idealization of oneself and a covert type that is typified by the devaluation of oneself and the idealization of others (Dickinson & Pincus, 2003; Gabbard, 1994; Wink, 1991). These two differing types of narcissism have been labeled with various terminology, most notably exhibitionistic versus closet narcissism (Masterson, 1993), grandiosity versus depression (A. Miller, 1997), grandiose versus depleted (Rathvon & Holmstrom, 1996), mirror-hungry versus ideal hungry (Wolf, 1988), oblivious versus hypervigilant (Gabbard, 1994), overt versus covert (Wink, 1991), and arrogant/entitled versus depressed/depleted (PDM Task Force, 2006).

In this paper, the terms exhibitionistic/grandiose and covert/depressive will be used interchangeably to describe these two manifestations of narcissism. In the two forms of narcissism (both adaptive and maladaptive), a common thread has been identified: self-interest and the need for admiration (Gabbard, 1994; Masterson, 1993; A. Miller, 1997; Pincus, 2004; Rathvon & Holmstrom, 1996; Watson et al., 2002; Wink, 1991, 1996; Wolf, 1988). Both narcissistic types attempt to repair and bolster self-esteem through admiration that is received through the reactions of others (Dickinson & Pincus, 2003; Wink, 1991).

Exhibitionistic or grandiose narcissism corresponds with the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (American Psychiatric Association, 2000) conceptualization of narcissistic personality disorder and has been widely examined (Dickinson & Pincus, 2003). Individuals with this personality organization admire themselves and not others, are arrogant and aggressive, are only interested in themselves, are exploitative and exhibitionistic, base their self-worth on their achievements and qualities, and outwardly appear to others as infallible and self-assured (Gabbard, 1994; A. Miller, 1986; PDM Task Force, 2006; Wink, 1991). Such individuals must maintain self-esteem by seeing themselves as better than others. They protect themselves against feelings of low self-worth by dominating and being dismissive of others (Dickinson & Pincus, 2003; Wink, 1991).

Based on clinical observation (Gabbard, 1994; McWilliams, 1994; A. Miller, 1986; Wink, 1991, 1996) and empirical investigation (Dickinson & Pincus, 2003), covert or depressive narcissism manifests differently than exhibitionistic or grandiose narcissism as it involves attempts to repair self-esteem and self-worth by serving others. It is the more vulnerable form of narcissism that is commonly exemplified by fears of rejection and criticism. For example, clinical (Gabbard, 1994; A. Miller, 1986; Wink, 1991, 1996) and empirical (Hendin & Cheek, 1997) evidence has shown that an individual with grandiose narcissistic characteristics will heighten his or her own sense of self and defend against flaws and imperfection, while an individual with covert narcissistic characteristics may reject any belief in his or her own inherent goodness and feel the need to heighten his or her view of others. The difficulties and struggles of the covert narcissist often include: high sensitivity to the reactions and needs of others, the deflection of attention from self to others, careful attunement to others for slights and criticism with a tendency to see the more negative aspects of others' communication, self-defeating attitudes, modesty, ingratiation, and low self-confidence manifested as a difficulty or inability to hear from others about strengths and accomplishments (Dickinson & Pincus, 2003; Gabbard, 1994; Glickauf-Hughes & Mehlman, 1995; Masterson, 1993; A. Miller, 1986; PDM Task Force, 2006; Wink, 1991). They attempt to achieve a sense of self-importance and success in attunement, thereby minimizing the critical or negative responses of others (Glickauf-Hughes & Mehlman, 1995; Grosch & Olsen, 1994; Masterson, 1993; A. Miller, 1997; Sussman, 1992). Individuals exhibiting covert narcissistic traits constantly seek others who will view and admire them for their ability to be selfless, thereby proving to themselves that they are worthy of praise and admiration.

## Psychotherapists and Covert Narcissism

Some important aspects of providing psychotherapy appear to connect to descriptions of covert narcissism: the importance of attunement and the one sided nature of therapeutic work. Attunement with and interest in the needs of the client are skills that psychotherapists depend on to form a collaborative therapeutic relationship with clients (Binder, 2004; Gelso & Hayes, 1998; Rogers, 1961). These abilities have been described as emotional antennae that allow the therapist to provide important qualities such as "sensibility, empathy" and "responsiveness" (A. Miller, 1997, p. 19). The need to selflessly attend to clients may be satisfied through psychotherapy. Additionally, psychotherapy is focused on helping one person, which leaves the therapist relatively protected from being known by the client (Epstein, 1994; Smith & Fitzpatrick, 1995). Therefore, psychotherapy may inherently be counterproductive to getting ones own needs met. For example, psychotherapy depends greatly on a working alliance that focuses on the needs and goals of the client to establish trust and safety (Gabbard & Lester, 1995; Gelso & Hayes, 1998).

Although one's own narcissistic needs may be met as part of being a therapist, it is important to recognize that striving for admiration and affir-

mation may be healthy and appropriate. Therapists may feel good or capable when a timely and accurate intervention is made in the service of furthering client exploration and growth (Grosch & Olsen, 1994) and there is nothing inherently problematic about the reaction. Additionally, it is not intended to imply that being interested in and involved with clients necessitates guilt around meeting needs. Psychotherapy can provide psychotherapists with boosts to healthy narcissistic strivings without being inherently manipulative of clients (Grosch & Olsen, 1994). Clinical experience and research have shown that experiences of narcissism are important in the development of the self and are part of healthy development for every individual (Banai, Mikulincer, & Shaver, 2005; Kohut, 1971; Kohut & Wolf, 1986; Watson et al., 2002; Wink, 1992; Wolf, 1988). Furthermore, there is empirical evidence that moderate amounts of these two forms of narcissism are associated with greater adjustment and fewer psychological difficulties (Lapsley & Aalsma, 2006). Indeed, it is quite healthy that psychotherapy can feel rewarding and satisfying, for both client and therapist in a mutual way (Grosch & Olsen, 1994).

The extent to which a therapist is motivated to attend selflessly to clients in an attempt to receive admiration may differentiate between situations where problematic covert narcissistic characteristics are operating or not operating. Accordingly, it is important to differentiate between therapeutic encounters that are useful and those that are potentially harmful to the client and prevent therapeutic change from occurring. The motivation to elicit admiration in service of covert narcissistic needs may then influence the psychotherapist negatively, which may in turn affect other aspects of psychotherapy (e.g., the psychotherapy relationship). Many psychotherapy orientations consider the therapist an important instrument of change in the therapeutic process (Binder, 2004; Gelso & Hayes, 1998). Potentially, the best therapeutic work occurs when psychotherapists are authentic and use their personality as the vehicle for change with less emphasis on specific technique or theory (Binder, 2004; Frank, 1999; McWilliams, 2004). However, therapeutic process and progress may become more complicated and problematic if therapists are searching to fulfill needs for admiration and acceptance through their relationship with the client. For those clinicians who have vulnerability toward covert narcissistic reactions or tendencies, the potential to achieve gratification and admiration by attending selflessly to others may be at its strongest when providing psychotherapy.

## Boundaries Defined

Psychotherapists widely agree that boundaries play a crucial role in the therapeutic process (Gelso & Hayes, 1998). However, there does not appear to be clear definitions and/or clear agreement of what differentiates healthy boundaries from boundary violations (Gabbard & Lester, 1995; Glass, 2003; McWilliams, 2004). This may be due, in large part, to the fact that boundaries are defined differently by each practitioner based on a variety of individual, social, cultural, theoretical, and administrative factors (Gutheil & Gabbard, 1998; McWilliams, 2004; Zur, 2007). For the purpose of this discussion, boundaries will be defined as therapeutic limits that allow for the protection of the client's best interests, thereby allowing for safety, reliability, and dependability (Gabbard & Lester, 1995; Gelso & Hayes, 1998; Glass, 2003; Gutheil & Gabbard, 1998; Smith & Fitzpatrick, 1995). The psychotherapist attempts to protect boundaries by maintaining focus on the client's difficulties as they relate to therapeutic goals, reducing or attending to the role of therapist opinion, and enhancing opportunities to increase client independence and autonomy (Epstein, 1994; Smith & Fitzpatrick, 1995). The purpose of establishing and maintaining boundaries is to ensure that therapy is geared toward helping the client and not motivated by therapist needs, gratifications, or agendas (Harper & Steadman, 2003; Smith & Fitzpatrick, 1995). When boundaries are compromised and not maintained, boundary transgressions occur that exist on a continuum ranging from adaptive (e.g., ethical and therapeutically useful boundary crossings) to maladaptive (i.e., antitherapeutic and potentially unethical) (Frank, 2002; Williams, 1997; Zur, 2007).

Boundary violations, which stand at the maladaptive end of the boundary continuum, are "serious" and "harmful" (Gabbard & Lester, 1995, p. 123), do not involve careful consideration by any therapeutic party, and occur when the therapist crosses the line of appropriate, decent, and ethical behavior (Slattery, 2005; Zur, 2007). They are characterized by having an absence of attenuation, involving the therapist's in-

ability or refusal to address the enactments, being pervasive in nature, and causing harm. Many theorists consider boundary violations as inherently unethical and exploitative, departing from normal practice, involving the misuse of power and influence, and causing harm to the client (Gabbard & Lester, 1995; Smith & Fitzpatrick, 1995; Zur, 2007). Some examples of boundary violations include illegal breaches of confidentiality, financial exploitation, abuses of power and exploitation, and sexual relationships (Glass, 2003).

Although from a clinical perspective interventions that maintain therapeutic boundaries are likely to be beneficial to clients, it can also be argued that some interventions that cross these boundaries may also be extremely therapeutic (Harper & Steadman, 2003; Smith & Fitzpatrick, 1995; Williams, 1997). Boundary crossings may be useful in the therapeutic process and further growth in the therapeutic relationship if they are in the interest of the client, conscious, intentional, or based on a sound conceptual formulation (Frank, 1999; Gabbard & Lester, 1995; Glass, 2003; McWilliams, 2004). For example, according to a psychodynamic model of psychotherapy, attempts by the client to use past patterns of relating to frame their own perceptions or feelings toward the therapist (transference) and the resulting reactions of the therapist to these perceptions and behaviors (countertransference) may be expected and useful in terms of building the therapeutic alliance and affecting change (Frank, 2002) if attended to and analyzed. Additionally, boundary crossings may occur intentionally (e.g., diverse cultural populations may benefit from more flexible boundaries between therapist and client, cognitive–behavioral therapists may provide therapy outside of the office) (Zur, 2007).

Conversely, boundary crossings and ineffective maintenance of boundaries may negatively affect the client and the therapeutic relationship when the they are not attended to, for the therapist, unconscious, automatic, or not part of an understanding of the client's patterns and dynamics. Furthermore, the proper maintenance and examination of boundaries may be one of the most important experiences for clients as the learn that they are capable of being treated as an independent adult and having mature relationships in which clear distinction is made between themselves and others (Binder, 2004; Epstein, 1994; Williams, 1997). Determining when boundary transgressions are helpful or harmful remains difficult because boundaries are flexible and tailored to specific therapeutic situations creating gray areas between healthy and unhealthy boundary transgressions (Glass, 2003; Harper & Steadman, 2003). Because there is a fine line between appropriate and inappropriate boundary transgressions, it is crucial to be aware of the many problems that may arise as a result of being a therapist.

## Boundaries, Covert Narcissism, and Psychotherapists

The following sections will examine the potential impact that therapist covert narcissistic tendencies may have on therapeutic management of boundaries in psychotherapy. This discussion is important as it is intended to highlight potential areas or indicators of therapist covert narcissistic tendencies that could lead to difficulty maintaining boundaries. It is important to make clear that the intention is not to label each specific scenario as a boundary crossing or violation, but to highlight a number of situations that occur in psychotherapy that may stem from covert narcissistic traits. It is the hope that this discussion will encourage self-reflection, self-awareness, consultation and supervision as these themes emerge within the unique context of the therapeutic relationship. Each section will first address the connection between areas of potential risk for boundary transgressions based on specific traits of covert narcissism. Second, examination of the possible implications of covert narcissistic tendencies on therapist's management of boundary-related dynamics in relation to the client, in the context of the therapeutic process and relationship, will follow.

### *Attempting to Reduce and Resolve the Client's Negative Experiences Toward the Therapist*

Through the illusion of constant benevolence, tolerance, and achievement (A. Miller, 1986; Sussman, 1992), individuals with covert narcissistic characteristics may attempt to secure the admiration from and connections with other important figures in their life by reducing the potential of negativity to be aimed at them (Dickinson & Pincus, 2003. There is clinical (A. Miller, 1986) and empirical (Dickinson & Pincus, 2003) evidence that the individual with covert narcissistic vulnerabilities may be sensitive to negativity and slights directed

toward them. As such, therapists may try to manage their own view of themselves as good (e.g., caretaker, provider) by trying to reduce others' anger, resentment, and disappointment that naturally emerge as part of relationships. Attempts to reduce negativity and increase others' acceptance may be a way for the therapist to avoid being seen as flawed and unhelpful, thereby preventing feelings of devaluation and emptiness.

The therapist's attempts to assuage the subjective negative experiences and reactions of clients may affect the therapeutic process and the boundary between client and therapist in a variety of ways. The psychotherapist's efforts to reduce negative reactions may leave the client unable to confront and experience their own emotions, thereby not allowing for acknowledgment of the existence or the expression of negative feelings (e.g., anger, disappointment) toward the therapist or others (A. Miller, 1997). Controlling the discourse in therapy so that only positive experiences occur may be problematic for both clients and therapists. In the case of the former, it may recapitulate the negative experiences that clients have had in the past and in the case of the latter may be an attempt to use clients to receive admiration. By extending sessions past normal time limits and by making special concessions, the therapist may be trying to resolve the client's negative experience, sacrificing boundary maintenance in an effort to apologize for creating an atmosphere where negativity occurs. Additional difficulties may emerge as therapists attempt to reduce and resolve negative reactions and attempt to elicit positive views from their clients. For example, a psychotherapist may pay an inordinate amount of attention to patient strengths, avoid confrontation, and constantly reframe patient difficulties into strengths in an attempt to reduce their own discomfort with negativity. Difficulties accepting clients' negative reactions may create an environment in which clients cannot see the therapist as anything but positive and may serve to convey the message that negative emotions toward others should be avoided because they may injure others. As clients struggle to express their negative reactions toward the therapist's comments or behaviors, they may feel reluctant to divulge an important part of their experience. This may serve to reinforce the client's expectation that they must take care of the therapist. Additionally, it may also lead to a belief that they too must negate their feelings of anger and frustration in an attempt to remain close to others. The freedom for the client to express the full range of human emotion is thwarted, thereby possibly halting movement toward change.

### *Denial of Emotions Toward Clients*

Depressive narcissism involves difficulty accepting one's own emotional reactions (A. Miller, 1997) and denying negative feelings (e.g., frustration, disappointment, sadness, resentment) toward others as a means of protection against the pain (e.g., intrusiveness) of devaluation that has been experienced in the past. The experience of therapy may create a conflict in the therapist with covert narcissistic characteristics between competing wishes for interpersonal closeness and emotional distance from others. For example, in the past therapists may have gained attention and admiration when their own needs and feelings were ignored, leading to praise for being unemotional and selfless in relation to others. Therapists with covert narcissistic tendencies may be unaware that they hold a belief that they must not have negative feelings and that they must not have needs concerning others because they must be seen as needless for fear of criticism and rejection.

Therapists who have difficulties acknowledging their feelings toward their clients may create an expectation that the therapeutic relationship is free from negative reactions. The denial of feelings in therapy may support and eventually exacerbate the therapist's difficulty expressing emotion, potentially hindering therapeutic process. For example, the tendency of therapists to deny their feelings, especially when attraction to and interest in clients is an expected and understandable phenomenon, may foster denial of the client's reality and create inauthenticity in the therapeutic work. Additionally, a therapist's reluctance to acknowledge his or her own feelings toward a client may deny the client the experience of having a real relationship with the therapist and create false expectations of others' selflessness in relationships. It is only through acknowledgment and awareness of reactions to clients that therapists can evaluate whether their reactions may be useful or harmful, thereby leading them to either include them in treatment (e.g., disclosure) or seek consultation.

*Chronic Criticism of Self in Therapy*

Periodic reflection and deep examination of one's work is an important facet of competent psychotherapy (Binder, 2004). Additionally, the ability to recognize fallibility and admit one's (albeit expected and human) mistakes is an important trait to have as a psychotherapist because it models and normalizes the negative feelings and subjective failures that clients may harbor in themselves (Field, 1992). However, psychotherapists can take too much responsibility for the process and outcome of psychotherapy, either by attributing all gains to their own prowess or by taking complete responsibility for a lack of progress and attending to only perceived flaws and difficulties. This latter description fits with covert narcissistic tendencies in psychotherapists. Because of the tendency of covert narcissists to engage in devaluation and their preference to attribute difficulties to deficits of the self, the therapist's critical examination of his or her own therapeutic work may become detrimental to the therapeutic process if covert narcissistic characteristics are evident. Individuals with covert narcissistic tendencies believe that they deserve to be devalued, creating a belief that failures in psychotherapy are "truly symbolic of the failures of the self" (McWilliams, 1994, p. 174). Mistakes are a reminder of one's deficits, and perfection through a false identity of perfect attunement is one way to push feelings of incompetence out of awareness. The psychotherapist may create standards that are stricter than what they expect from others. For example, one's own mistakes are seen as intolerable while mistakes made by others are normalized and seen as part of the human condition (A. Miller, 1986). As the therapeutic process unfolds and therapeutic failures, mistakes, flaws, and ruptures emerge as a result of the inherent imperfection in responsiveness of the psychotherapist, stereotypic ways of dealing with criticism by taking all responsibility for perceived wrongdoings or lack of progress may emerge.

The constant debasement of one's abilities and performance can have adverse effects on the client. Based on more modern theories of psychotherapy that posit intersubjectivity and the importance of mutual responsibility in creating the therapeutic frame and relationship (Frank, 2002; Gabbard & Lester, 1995), constant criticism of oneself by the therapist may create more ruptures and difficulties than it is believed to help (or protect against). For example, interventions aimed at increasing client self-esteem and ownership in the mutual therapeutic process may be boundary transgressions as the therapist attempts to secure admiration for being selfless. Sensitivity to potential slights of the client in therapy (Gabbard, 1994; Gabbard & Lester, 1995) may lead to excessive apologizing and taking of responsibility for the difficulties and absence of progress in psychotherapy. The therapist may even feel guilty about such difficulties. Trying to reduce the appearance of these slights may create conscious and unconscious attempts to deceive the client into believing that the psychotherapist is capable of being the perfect person who can take responsibility for all of the client's flaws. The result is a missed opportunity for growth and acceptance, as the therapist is unable to model mutual responsibility and interaction in relationships. Difficulty managing boundaries occurs as the psychotherapist takes more and more responsibility for the outcome of psychotherapy and believes the complicated nature of psychotherapy is evidence of failure. For example, as the therapist becomes increasingly critical of themselves, he or she may become less responsive and attentive in session to manage the pressure to take care of the client.

*Providing Unconditional Love*

Unconditional love is the wish by the developing infant to receive all-encompassing and constant attention and affection from the caregiver or mother (A. Miller, 1986, 1997). Some depressive narcissists may be motivated by the constant search for unconditional love that was absent early in childhood because of their caregiver's needs for love and affection being met in lieu of their own needs for the same attention. However, the process of *giving* unconditional love is a familiar one for the therapist who struggles with covert narcissism, one that is reminiscent of the need in children to provide unconditional love to the parent. Some psychotherapists may be motivated to enter this profession because of a wish to receive love from others (Grosch & Olsen, 1994). The constant fear that love is contingent on what one does for others may get enacted in therapy and may impel the therapist to give the promise of unconditional love as he or she gave to others in the past. Accordingly, for the therapist, love is attainable through constant achievement of giv-

ing unconditional love at all costs. These attempts to actively soothe others through constant admiration and unconditional love may be efforts to receive constant admiration and unconditional love in return from them. This pattern parallels childhood attempts to engender love from caregivers, often accomplished through the development of specialized abilities to be emotionally attuned to them (Gabbard & Lester, 1995; A. Miller, 1986).

Attempts to provide unconditional love in psychotherapy may lead therapists to cross boundaries in an effort to secure admiration. The role of the therapist is not to gratify archaic needs for unconditional love and affection (Gabbard & Lester, 1995), but therapists may strive to provide unconditional love to their clients. Note that this is different from the concept of unconditional positive regard proposed by Rogers (Rogers, 1961). Unconditional positive regard is a disciplined approach to therapy whose beneficiary is the client; on the other hand, unconditional love, as proposed in this paper, is an unattainable childhood fantasy whose beneficiary is the therapist. The therapist with covert narcissistic tendencies attempts to demonstrate to the client his or her capacity to provide constant affection and admiration. For example, the therapist might give their client gifts, forgive absences of payment, and have greater difficulty setting time and contact limits. Other potential boundary transgressions of a more implicit nature can also occur as a result of a wish to provide unconditional love to the client. For example, the psychotherapist may frequently and persistently attempt to actively soothe the client, potentially compromising boundaries because of the motivation and wish to be the perfect parent who is capable of providing unconditional love to their child (Gabbard & Lester, 1995). Improvement in therapy for the client, however, may become increasingly difficult to achieve because the therapist's attempts to provide unwavering love and affection may stunt the client's ability to acknowledge their own unrealistic wish to be unconditionally loved. Furthermore, it can shift the focus of psychotherapy to the therapist's needs to provide and soothe, leaving the client vulnerable to expectations of constant support and comfort from others. For example, providing unconditional love may leave the client unexposed to optimal frustration that allows clients to develop their own internal means for self-soothing.

*Making Connections for the Client*

The pressure to provide intellectual and emotional connections for clients may be prominent in psychotherapists who struggle with covert narcissistic tendencies. Attempts by such psychotherapists to make connections may come from unconscious motivations involving the need to have others affirm their own self-worth. Because the therapist's knowledge and ability to understand others' difficulties and needs was seen as an important function that the therapist could serve in childhood, the therapeutic relationship can bring about longstanding and embedded fears related to the emotional function that he or she once served for others. Providing others with the connections that they must make on their own to achieve emotional and intellectual awareness may be intrinsically tied to the need of the therapist to prove his or her worth to others and demonstrate achievement in an attempt to create admiration in relationships (A. Miller, 1986, 1997). Specifically, psychotherapists with covert narcissistic characteristics may believe that approval and confirmation are dependent on what connections they offer others and not based on who they truly are.

Providing a therapeutic environment for self-discovery and awareness is an important boundary in psychotherapy, even when interpretation may help increase awareness. Although the proper use of interpretation and clarification in therapy are necessary components of treatment, frequent and repetitive interpretation may compromise the boundary between therapist and client as the therapist attempts to provide for the client at the expense of the client's needs (A. Miller, 1997; Ogrodniczuk, Piper & Joyce, 1999; Piper, Azim, & Joyce, 1991). Studies have shown that excessive interpretation that is not based on the conceptualization of the client leads to less favorable outcome and poorer therapeutic alliance (Piper, Joyce, McCallum, & Azim, 1993; Piper, McCallum, Azim & Joyce, 1993). Boundary transgressions such as these may manifest in session as frantic and repetitive attempts to connect present relationship difficulties with struggles with parents without appreciating contextual factors (e.g., quality of object relations, therapeutic relationship that may be important) (Piper, Joyce et al., 1993). The therapist attempting to further the awareness and conscious understanding of the client's own past and present struggles

by constantly attempting to provide greater cognitive and emotional understanding in their clients may only frustrate the client's attempts to arrive at awareness on his or her own and may repeat the past failure of others to allow for self-discovery (Kohut, 1971). The importance of client participation and collaboration in the therapeutic process is an important facet of change (Binder, 2004; Frank, 2002). Attempts to replace a client's own discovery and awareness by providing intellectual and emotional connections between the past and present may move therapy at a faster pace than what is therapeutic for the client, compromising boundaries. For example, a therapist may push the treatment too fast to feel more helpful and useful, but may not be taking into account the client's own level of readiness or awareness. Attempts like this may be perceived by the client as intrusive and demanding. Autonomy might be discouraged (Epstein, 1994) and dependency may be created as the therapist takes on greater responsibility in the relationship by not allowing the client to discover connections on his or her own.

### *Absence of the Therapeutic Frame*

The therapeutic frame is a reasonable set of guidelines that assists in establishing an atmosphere in which safety and trust emerges, thereby protecting the client from harm by creating "ground rules, the reliable circumstances under which the therapy takes place" (McWilliams, 2004, p. 100). The frame exists as a contract between therapist and client as to what can be expected in treatment (Frank, 1999) and often includes rules such as the length of sessions, the duration of therapy, the nature of the therapeutic relationship, and informed consent. However, because of potential covert narcissistic tendencies in therapists, there may be greater potential for boundary transgressions related to difficulties in the establishment of the frame. For example, individuals with covert narcissistic personality characteristics do not wish to upset others and may resist demands to establish rules that may potentially create distance in relationships with others. These individuals may not have had the opportunity to set their own boundaries and guidelines in relationships, potentially leading to the need to depend on others to establish roles in relationships and avoidance of decision making that may potentially anger others.

There are many circumstances in which loosening of the therapeutic frame is useful and beneficial to the client (e.g., when working with clients from diverse backgrounds) or when self-disclosure may increase the client's awareness of enactments (Frank, 2002). For many clients, the frame must be tailored and flexible to develop a collaborative therapeutic alliance (Zur, 2007). In these cases, the therapist deliberately modifies the frame to achieve some specific goal that benefits the work and the client. However, nondeliberate attempts at making the professional relationship between therapist and client more intimate, personal, and friendly may reduce the therapist's availability to the client as a professional helper and negatively impact the working relationship. The creation of dual relationships may be motivated by the wish to be seen in a positive light. For example, psychotherapists may find themselves meeting frequently with their clients outside of the office, may attend personal or social events with increased frequency (e.g., weddings, funerals), and may begin to disclose more and more personal information that does not serve the interests of the client or the goals of therapy. The therapist may begin to believe that they do not need to adhere to the therapeutic frame because they know how to best help their client. This may lead, at its most extreme, to friendships and romantic relationships between therapist and client.

### *Avoidance of Termination*

The self worth of individuals with covert narcissistic tendencies cannot be separated from the availability of others to provide needed boosts to self esteem. For example, anticipated loss of others may ignite fears that there will be nobody left to provide admiration for being selfless and available. The pull to have others around to fulfill needs for admiration and affirmation remains strong when these tendencies go unrecognized. These messages may stem from therapists' unconscious fears that other people will not need them anymore and that their worth is only exhibited by what they can provide for others. Historically, individuals with covert narcissistic characteristics have lacked a sense of existence in the absence of the opportunity to give to and be selfless for others. The pressure to provide for others may

lead to difficulty managing loss and the end of relationships with others.

Empirical evidence has suggested that many therapists have difficulty separating from their clients and working on termination (Epstein, 1994). Avoidance of termination can serve to divert attention in psychotherapy away from the needs of the client, creating difficulty in managing boundaries that aim to support client growth and development. As clients make progress and begin to achieve some resolution of the conflicts that brought them into therapy, the therapist may fear the loss of those who provide admiration and a sense of self (McWilliams, 1994). The desire to hold on to a client who appreciates and values the therapist may discourage the client from ending psychotherapy when termination may be in his or her best interest. Therapists may keep clients too long in therapy or may have a difficult time recognizing when change has occurred because of the fear of losing someone who provides necessary boosts to self-esteem. Any messages that the therapist receives that may threaten the loss of someone who they have helped may thwart his or her ability to attend appropriately to their client's accomplishments and wishes for autonomy. For example, psychotherapists may discourage client independence by communicating to the client the importance of remaining in therapy as the only way to maintain change and positive results. Therapists may attempt to provide throughout the course of treatment both implicit and explicit messages around the client's need for therapy (in particular, the client's need for the therapist) to achieve growth. For instance, this may be achieved by sending messages to clients regarding their inability to achieve support, help, or improvement without the therapist. Conversely, therapists may prematurely terminate with other clients who frustrate the wish to be seen positively through attunement and selflessness. Additionally, therapists may develop envy for their clients' increasing ability to be separate and independent as the client learns and benefits from the therapist's empathic understanding (Epstein, 1994). This may create a wish that he or she could have the same autonomy and individuality in their relationships with others that their clients are expressing.

## Considerations for Treatment, Training, Supervision, and Consultation

### *Treatment*

Given the potential for covert narcissistic traits in psychotherapists and the meaning this connection has for the management of boundaries in psychotherapy, awareness of the difficulties inherent in therapeutic work is essential to both maintain appropriate boundaries in therapy and maintain adequate satisfaction in therapeutic work. Without awareness of the particular historical and interpersonal dynamics that influence why individuals become psychotherapists and how they practice psychotherapy, clinicians may repeatedly attempt to resolve unconscious emotional and developmental conflicts in their work, further increasing susceptibility to more serious transgressions (e.g., boundary violations). The potential problems with therapists' lack of awareness of the need for admiration and affection from clients can lead not only to an increased incidence of boundary transgressions that impact the therapeutic process and limit client's ability to change, but also to burnout, withdrawal, job dissatisfaction, and overworking (Grosch & Olsen, 1994; Sussman, 1992). The perils of unawareness can further lead to boundary violations, ethical charges from clients and colleagues, malpractice suits, loss of licensure, an inability to practice psychotherapy, and litigation (criminal or civil). However, psychotherapists struggling with covert narcissistic tendencies who are likely to have difficulties expressing emotional content, and a strong urge to deny emotional reactions, may find it hard to admit to having difficulties and may believe that they cannot depend on others who will have their best interests at heart.

In considering the question as to why one may choose an occupation of psychotherapy, one reason may involve an underlying wish to resolve early childhood conflicts that resulted in emotional disconnectedness (A. Miller, 1997; Sussman, 1992). This should not be seen as a condemnation of the choice of psychotherapy as an occupation. Rather, it is a compelling reason for the increased awareness of the perils that psychotherapeutic practice may have for those who operate under the assumption that they must meet the needs of others before they meet their own needs and wish to get admiration, affection, and love from their clients. The knowledge of the unconscious underpinnings of choosing

psychotherapy may allow therapists to further deepen their work (Sussman, 1992). For example, awareness of internal struggles and needs may release therapists from the internal pressure to succeed and cure clients of their ailments; this, in turn, is likely to prevent the stifling of therapists' ability to use knowledge of themselves as an instrument in treatment. Additionally, out of the struggle to be aware of emotional needs may grow a greater ability to be empathic (Sussman, 1992) as well as a greater appreciation and acceptance of how psychotherapists can get their needs met appropriately through clinical work (Grosch & Olsen, 1994). The need to be admired and thought of in a positive light becomes problematic when therapist's needs are greater than the needs of his or her clients.

The work of becoming aware begins with the psychotherapist's careful examination of how perceptions, beliefs, needs, wishes and emotions emerge in the relationship with his or her clients; and then how those same perceptions, beliefs, needs, wishes and emotions intertwine with the therapist's own development and current interpersonal relationships. Exploration of the beliefs one has (both about the role of psychotherapists and clients) can immediately trigger emotional and relational patterns that correspond to patterns in psychotherapy. Awareness, however, is not an easy state to achieve by oneself. Often, psychotherapists who have covert narcissistic leanings may justify that their abilities to be empathic and create safety are unique and make them special. The therapist may also feel that his or her ability to be selfless is proof that he or she is capable and that without his or her ability to make specific concessions for clients he or she would be negligent and deficient in his or her role as a psychotherapist. Individual psychotherapy, support groups for psychotherapists, group psychotherapy, supervision, and consultation are important for future prevention of pervasive and repetitive difficulty managing boundaries, which may lead to greater susceptibility to boundary violations.

### *Training*

In their efforts to educate competent therapists, graduate training programs may also benefit from open discussions of the relationship between psychotherapist's needs (e.g., attention, admiration, suppression of emotional needs, dependence on clients) and psychotherapeutic work. Early introduction of the connection may serve to normalize emerging feelings as trainees begin psychotherapy training and may increase exposure and awareness of the tendencies that psychotherapists may encounter in clinical work. The unconscious motivations underneath becoming psychotherapists should be explored with particular attention to therapists' own personal development and interpersonal dynamics, as well as wishes and fantasies about entering into work in psychology. Training programs "do little to encourage students to be open about their emotional struggles as trainees and novice clinicians" (Sussman, 1992, p. 250), which may replicate developmental experiences of needs going unmet because of others' inability to attend to or see as important emotion and subjective experience. Furthermore, classes rarely cover topics such as the needs and struggles of psychotherapists, preferring to focus more on client needs (potentially creating an environment that perpetuates the belief that the psychotherapist must be something different from human). Courses in ethics, supervision, consultation, psychodynamic psychotherapy, and general psychotherapy training, as well as seminars on practicum and professional development, would be excellent forums to discuss such topics. There could be many benefits for psychotherapists entering the field if the role of covert narcissistic traits (should these emerge) is explored by senior psychotherapists whose ability to be vulnerable may model an acceptance of one's own needs in the work and further lead to acceptance, understanding, and awareness.

### *Supervision and Consultation*

Supervision and consultation can also help identify covert narcissistic traits while simultaneously providing validation to psychotherapists striving for admiration and dependence from clients. Supervisors may notice trainees struggling with expressing emotional reactions, for example having difficulty in terminating with clients, not acknowledging emotional content, and working very hard to get clients to like them creating avoidance of confrontation and negative comments. The supervisor may be able to notice patterns that occur in psychotherapeutic work, connect them to needs for admiration, and be able to facilitate how to work with clients that may engender covert narcissistic reactions based on the therapist's own history or psychosocial factors. This also includes exploration of sexual

wishes and strivings that when addressed may prevent the propensity for boundary transgressions from the least harmful boundary crossings to the most severe and unethical sexual boundary violations. If issues continue to arise that are related to covert narcissistic traits, then supervisors may refer therapists to psychotherapy for further exploration around how personality dynamics may impact therapeutic work. Supervisors may be the first line of defense, being that they are often the first to view clinical work with clients. Therefore, it seems of importance that the struggles that psychotherapists may face as a result of covert narcissistic vulnerabilities are identified, examined, and explored in the context of clinical supervision or consultation to best connect how those same struggles may impact work with clients and may be used to further the therapeutic relationship (Frank, 1999).

## Concluding Thoughts on Boundaries and Covert Narcissistic Personality Characteristics

Covert narcissistic characteristics in psychotherapists may compromise the maintenance of boundaries in psychotherapy. This paper does not intend to suggest that all or even most psychotherapists have covert narcissistic tendencies. Furthermore, covert narcissistic tendencies do not automatically have a negative effect on boundary maintenance or psychotherapy outcome. Conversely, it is impossible to state that psychotherapists who have covert narcissistic traits or get their needs met as a result of the therapeutic relationship will unequivocally violate boundaries between themselves and their clients (Gabbard & Lester, 1995). In fact, it is likely that these traits contribute to positive therapeutic outcome and a greater ability to attune to clients within the unique therapeutic context and relationship. Instead, this paper states that in some therapeutic situations, it is possible that unexamined communications, interactions, or interventions will be impacted by therapist covert narcissistic tendencies. An attempt was made throughout this paper to highlight specific therapeutic situations to increase therapists' recognition and awareness of themes that may emerge and compromise the boundaries between themselves and their clients.

In addition to personality characteristics and traits, environmental factors (especially those that activate covert narcissistic tendencies) are likely to increase the susceptibility of psychotherapists to have difficulty maintaining boundaries. Specifically, relational, financial, familial, and other struggles can affect therapeutic functioning and the ability of the psychotherapist to maintain the boundaries that are necessary for the creation and maintenance of the therapeutic frame as well as positive therapeutic outcome. For example, divorce, bankruptcy, loss of a parent, or a sudden decrease in client caseload (potentially creating difficulties in multiple areas) may heighten covert narcissistic strivings and make the therapist more vulnerable to violations related to their needs for self-esteem and admiration. Therefore, boundary transgressions may occur even if psychotherapists do not identify with the developmental trajectory of the covert narcissist.

Because of the possible implications that the inability to manage boundaries may have for bringing about negative therapeutic process and outcome, the field may benefit from future research that aims to understand more completely those narcissistic factors that may increase psychotherapists' susceptibility to the whole continuum of boundary transgressions. Empirical investigation into the specific intrapsychic, interpersonal, and environmental factors that may reduce therapists' awareness, influence the therapeutic relationship, and potentially affect outcome would be valuable. Additionally, understanding what specific difficulties in psychotherapists lead to greater potential for boundary violations and ethics complaints could be useful for training and prevention. Of additional note is the lack of empirical investigation into the connection between empathic attunement and covert narcissism, as well as the positive role that covert narcissistic traits have on the therapeutic relationship.

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