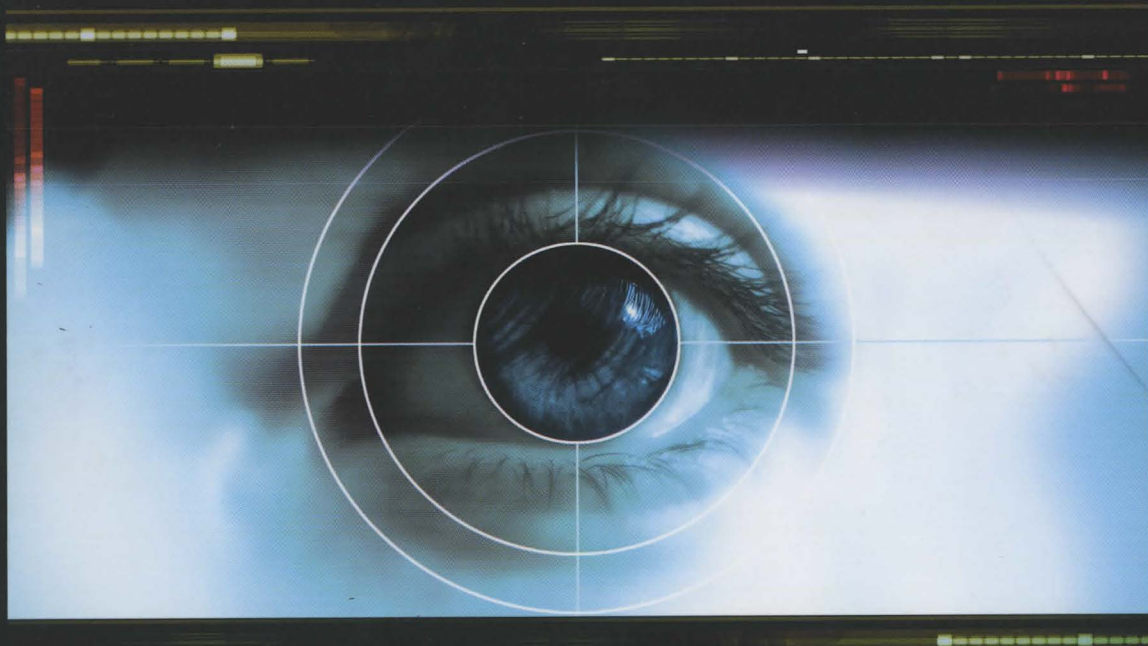


Understanding and Treating **Pathological Narcissism**



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INTRODUCTION

JOHN S. OGDONICZUK

Warnings of the perils of vanity and self-centeredness can be traced through humanity's history in biblical, mythological, and other types of writings. These writings, perhaps the best-known of which is the Greek myth of Narcissus, have contributed to what, today, we understand as *narcissism*. As suggested by these ancient writings, *narcissism refers to self-investment. A moderate degree of self-investment (i.e., healthy or normal narcissism) consists of a reasonable and measured capacity for sustaining positive self-regard.* Considered an adaptive and crucial aspect of healthy functioning, this capacity entails a realistic appraisal of one's personal attributes coupled with a capacity for empathy toward others (Stone, 1998). Accordingly, healthy narcissism is required for a sense of personal agency, the pursuit of ambitions, and the preservation or restoration of self-esteem in the face of disappointment or frustration. In contrast,

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pathological narcissism “involves significant regulatory deficits and maladaptive strategies to cope with disappointments and threats to a positive self-image” (Pincus & Lukowitsky, 2010, p. 426). In other words, individuals with pathological narcissism lack appropriate mechanisms for the healthy maintenance of positive self-regard.

NARCISSISM: DEFINITION AND THEMES

Both healthy and pathological expressions of narcissism are encompassed within a functional definition of narcissism that was proposed by Stolorow (1975). Narcissism is thus conceived of as any mental activity that serves to “maintain the structural cohesiveness, temporal stability, and positive affective coloring of the self-representation” (Stolorow, 1975, p. 181). Implicit in this view is the notion that narcissism is expressed on a continuum, from healthy and adaptive at one end of the spectrum to pathological and severely maladaptive at the other. Whether narcissism is actually a continuous personality trait and whether a fundamental difference exists between healthy and pathological narcissism continue to be debated in the literature (see Pincus & Lukowitsky, 2010).

Two principal kinds of narcissistic dysfunction, described with varying terminology, have appeared consistently in the literature. Cain, Pincus, and Ansell (2008) distilled the various descriptive labels from the literature into (a) grandiose themes and (b) vulnerable themes. *Grandiose* themes refer to self-inflation, arrogance, and entitlement, all of which reflect intrapsychic regulatory processes such as fantasies of unlimited success and disavowal of negative self-representations. By contrast, *vulnerable* themes refer to feelings of helplessness, suffering, and anxiety regarding threats to the self—feelings that reflect a sense of inadequacy, emptiness, and shame (Kealy & Rasmussen, 2011).

Building on the review by Cain et al. (2008), Pincus and Lukowitsky (2010) further distinguished between types (grandiosity and vulnerability) and expressions (overt and covert) of narcissism. Grandiosity and vulnerability may each be either overtly or covertly expressed. For example, vulnerable themes of fragility and depletion may be predominant and overtly expressed, yet grandiose fantasies may hover covertly in the background. Likewise, overt arrogance can mask covert feelings of inadequacy (Pincus & Lukowitsky, 2010). From this perspective, narcissistic subtypes may be more appropriately considered as states that operate in a dialectical and reciprocal manner. Although many patients might evince one or the other theme much of the time, the contrasting theme remains psychologically salient, albeit unexpressed and not immediately perceptible (Kealy & Rasmussen, 2011).

In this way, a degree of expressive fluctuation between grandiosity and vulnerability is likely for most patients with pathological narcissism, varying in accordance with experiences of success or failure and interpersonal acclaim or rejection (Ronningstam, 2009). For example, an individual who struggles with overt shame and inhibition might reveal previously hidden grandiosity on receiving some encouraging external recognition. Likewise, an individual who is rejected by a friend or romantic partner might experience feelings of profound inferiority and weakness, which may surprise those who thought of him or her as confident and self-assured (Kealy & Ogrodniczuk, 2011). The presence of self-regulatory deficits involving distorted or fluctuating self-esteem has been recommended for the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*; see <http://www.dsm5.org/Pages/Default.aspx> as being more indicative of narcissistic personality disorder than the grandiosity emphasized by the criteria in the fourth edition (text revision) of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V-TR)*; American Psychiatric Association, 2000; Ronningstam, 2011b). The changes to the diagnosis of narcissistic personality disorder proposed for DSM-5 better reflect these self-esteem fluctuations and the compromised interpersonal functioning associated with them.

The self-regulation deficits in pathological narcissism represent a serious form of personality psychopathology and have long been recognized as having a deleterious effect on the individual self and others. Conceptual and clinical reports have linked pathological narcissism with stalled personal accomplishments, superficial relationships, and later-life emptiness and dread (Kernberg, 1984; Kohut, 1968). Pathological narcissism has also been described as underpinning intense rage reactions (Kohut, 1972) and, for some individuals, the descent into severe suicidal states (Ronningstam, Weinberg, & Maltsberger, 2008). Empirical reports have provided further information regarding the problems associated with pathological narcissism. These other areas of pathology include DSM Axis I disorders (Bachar, Hadar, & Shalev, 2005), psychiatric distress and functional impairment (Miller, Campbell, & Pilkonis, 2007), interpersonal problems (Dickinson & Pincus, 2003; Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009), psychopathy (Paulhus & Williams, 2002), depressive tendencies (Kealy, Tsai, & Ogrodniczuk, 2012), impulsivity (Vazire & Funder, 2006), suicidality (Links, Gould, & Ratnayake, 2003), perpetration of child abuse (Wiehe, 2003), and substance abuse (Luhtanen & Crocker, 2005). These findings, taken together with numerous anecdotal reports and social commentaries, substantiate the problematic nature of narcissistic pathology. Adding to the seriousness of pathological narcissism is the widespread notion found throughout the clinical literature that it may be a particularly difficult form of personality pathology to treat.

TREATMENT AND RESEARCH

The topic of treating pathological narcissism generates intense, and at times opposing, reactions from clinicians. These reactions include fear, pessimism, and a sense of therapeutic nihilism but also fascination, hope, and a sense of obligation and responsibility to know more and do more to help patients who present with pathological narcissism. Despite the problems associated with pathological narcissism and the abundant clinical and theoretical literature dealing with the subject, there are no clear, empirically based guidelines for treatment. Psychotherapy, often of long-term duration, is generally considered to be the primary treatment for pathological narcissism. However, no randomized clinical trials of pathological narcissism treatments or naturalistic treatment studies involving patients with pathological narcissism have been reported. This is not to say that patients with narcissistic pathology are not receiving treatment: Narcissistic personality disorder is a consistently represented diagnosis in clinical practice (Morey & Ochoa, 1989; Westen & Arkowitz-Westen, 1998), and one survey reported that 25% of psychotherapy outpatients had this diagnosis (Doidge et al., 2002). Furthermore, the clinical literature abounds with case reports of psychotherapy for narcissistic dysfunction, and patients with pathological narcissism have been included in studies of transdiagnostic personality disorder treatment (e.g., Ogrodniczuk et al., 2009). General practice guidelines for working with narcissistic patients (e.g., Kealy & Ogrodniczuk, 2012; Ronningstam, 2011a) are helpful, but they are limited by the absence of empirical findings to ground recommendations.

The limited research regarding the treatment of pathological narcissism is a significant concern, and it is perhaps surprising given the amount of attention paid to narcissism in the clinical literature. In addition, mental health services have increasingly prioritized clinical research and evidence-based practice, yet the treatment of pathological narcissism has thus far received little attention. Paradoxically, this evidence-based climate—implemented to promote patient safety, treatment efficacy, and quality control—may place patients with pathological narcissism at risk of being excluded from treatment because policymakers may be reluctant to fund treatments that lack an empirical basis. Most of the literature on the treatment of pathological narcissism is theory driven and organized according to different schools of thought usually aligned with the seminal works of Kohut (1971) and Kernberg (1984). Using empirical research to establish consistent treatment guidelines would thus appear to be highly desirable, to promote optimal outcomes and to reduce iatrogenic effects among a patient group that is often labeled “difficult to treat.” I hope this book stimulates efforts to study the effectiveness of different approaches to treating pathological narcissism.

However, narcissism is considered difficult to comprehend, let alone to remedy. Clinicians who seek to learn more about pathological narcissism have access to an extensive literature that, for many, can seem overwhelming. Less available, however, is a succinct yet comprehensive overview of literature relating to the treatment of pathological narcissism, the absence of which is a significant obstacle to providing effective care to patients who suffer from its debilitating effects. It is my hope that this book, which attempts to help fill this void in the literature, will assist clinicians in developing a better appreciation of the complexities of pathological narcissism and the strategies that can be used to treat it.

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personality inventory (Raskin & Hall, 1979), followed 1 year later by the inclusion of narcissism as a personality disorder (*Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed.; *DSM-III*; American Psychiatric Association, 1980). Considerable clinical, experimental, and theoretical work on narcissism has been undertaken since then (Cain, Pincus & Ansell, 2008).

THE ANCIENT GREEK MYTH OF NARCISSUS

The term *narcissism* evolved from the ancient Greek myth of Narcissus, a young, beautiful boy who rejects the love of others as unworthy and falls in love with his own reflection in water. The longer he stares at his own image, the more he is driven by both passion and heartache, and over time he dies in this state of despair. The ancient Greek story has been told in various versions by ancient writers, and each ends in tragedy. In the earliest known version (which dates to around 50 BCE and is attributed to Virgil's tutor, Parthenius of Nicaea), a spurned male suitor persuades a god to make the self-obsessed but beautiful Narcissus stare at his image forever. This drives Narcissus to commit suicide; he collapses in a pool of blood (Keys, 2004). This early version whereby Narcissus commits suicide was later also adopted by Conon, a mythographer and contemporary of Ovid in his *Narrations* number 24 (Conon, 25 BCE/1738). In the version by Ovid (AD 8/1717), Narcissus melts and withers away from heartbreak. In another version by Pausanias (AD 143–176; Habicht, 1985), written some 100 years after Ovid, Narcissus falls in love with his identical twin sister and has a sexual relationship with her. When she dies, he pretends to see her reflection in the water to recall his love of her. Each version includes an erotic component—for Parthenius it is spurned homosexual love, for Ovid it is self-love and the nymph Echo's unrequited love for Narcissus, and for Pausanias it is intrafamilial incest. The version that is the best known, with the broadest appeal, and also the longest with the most developed plot, belongs to Ovid.

Ovid's version (AD 8/1717) is written in the hexameter epic narrative poem style. Narcissus comes upon a perfectly clear pool of water that has not been disturbed by any animal or leaves and, being thirsty, lies down to drink. He falls in love with the reflection and tries to embrace and kiss the beautiful boy he sees, disturbing the water. At first, he does not recognize the image in the lake as his own ("Nor knew, fond youth! it was himself he lov'd"). This unrequited love leads him to neglect sleep and food, and he is gradually tortured by the person in the water, calling for him: "My lips to his, he fondly bends to mine. / Hear, gentle youth, and pity my complaint, / Come from thy well, thou fair inhabitant"—until he has insight—"It is my self I love, my self I see; / The gay delusion is a part of me." Prior to these events,

the seer Teiresias had prophesied that "Narcissus will live to a ripe old age, provided that he never knows himself" (Graves, 1955, p. 286). Narcissus's mother was a beautiful nymph who had attracted the attentions of the River god Cephisus. It is perhaps prophetic, therefore, that Narcissus's own fate be bound up with water.

The poem is in Book 3 of the *Metamorphoses*, a collection of 15 books in which the heroes are variously transformed into such things as animals, star constellations, trees, rocks, and flowers (Ovid, AD 8/1717). Narcissus's recognition of himself in the water is his downfall; he withers away in a pool of blood and is transformed into a white narcissus flower (an iris lily). At the time, balm distilled from this flower was used in temples. Derived from the plant was "narcissus oil," a narcotic. In fact, the word *narcotic* derives from the name "narc-issus." It is telling that the myth of Narcissus can also be understood as a tale about the effects of narcotics in terms of narcissistic bliss, that is, a euphoria of love and happiness bound up in a singular self-state (in drug abuse the state is that of the addict who is high on the substance). The word *narcissus* derives from the Greek word for sleep or numbness. It is therefore not surprising that 2,000 years later, modern analytic theories refer to drug abuse as a narcissistic disorder (Wurmser, 1974).

THE ANCIENT GREEK NYMPH ECHO

The tragedy of Narcissus provides a powerful narrative for modern psychological theories on the dangers and consequences of an unhealthy preoccupation with the self as love object. Thus, the roots of pathological narcissism as an important clinical diagnosis can be traced back to stories told at the beginning of civilization. Often overlooked in considerations of narcissism and the Greek myth is the important role played by the nymph Echo in the Ovid version. In the final scenes of the story, Narcissus and Echo are joined together in a tragic coupling. Echo, a lively and beautiful nymph, is punished for talking too much, in that by her love of talking and telling long stories she distracted the jealous Hera (Juno) from catching her husband, Zeus (Jupiter), consorting with other mountain nymphs. Echo is condemned to repeat the last words of what she hears others say: "She long'd her hidden passion to reveal, / And tell her pains, but had not words to tell: / She can't begin, but waits for the rebound, / To catch his voice, and to return the sound." In the final scene Echo, caught in an obsessive love of Narcissus, is unable to connect with him in her love, and he in turn rejects her for his own image. Thus wounded, Echo spends the rest of her days obsessed by both her love of Narcissus and his rejection of her and is only able to communicate with the words of others, not her own.

The significance of Echo to the story is that both she and Narcissus suffer in ways familiar today to our thinking about pathological narcissistic subtypes (Cain et al., 2008; Gabbard, 1989; see also Chapter 2, this volume). Narcissus, in love with his own unattainable image, represents the grandiose, oblivious subtype of narcissistic disorder. Echo, in her destructive obsessive love of another whose words she can only repeat, represents the fused hyper-vigilant narcissist, who can only live through another:

She answer'd sadly to the lover's moan, / Sigh'd back his sighs, and groan'd to ev'ry groan: / "Ah youth! Belov'd in vain," Narcissus cries; / "Ah youth! Belov'd in vain," the nymph replies. / "Farewel," says he; the parting sound scarce fell / From his faint lips, but she reply'd, "farewel." / Then on th' wholesome earth he gasping lyes, / 'Till death shuts up those self-admiring eyes (Ovid, 8 AD/1717)

Common to both Narcissus and Echo was the incapacity for healthy love and the escape from this in obsession with the self or with another. In this way, the early myths of Narcissus and Echo form early case studies in pathological narcissism, probably told, like most of the Greek myths, to illustrate and educate listeners and readers in the spectrum of human motives and behaviors.

TRANSFORMATION OF THE GREEK MYTH INTO A PERSONALITY TYPE

Since this powerful narrative was first told, Western civilization has found inspiration in art, drama, and poetry for retelling this story. For example, Milton (1667) in *Paradise Lost* cleverly pictures the process of coming across the reflection, and it bending and weaving along with the movements:

As I bent down to look, just opposite / A Shape within the watry gleam
appeerd / Bending to look on me, I started back, / It started back, but
pleasd I soon returnd, / Pleasd, it returnd as soon with answering looks /
Of sympathie and love, there I had fixt / Mine eyes till now, and pin'd
with vain desire.

Notable paintings include *Narcissus* by Caravaggio (1597–1599, Galleria Nazionale d'Arte Antica, Rome). Over time, painters turned their attention to more public manifestations of narcissism, particularly paintings of beautiful women entranced at their mirror, often with death symbols warning against this unhealthy obsession (the sin of vanity).

Up until the end of the 19th century, references to Narcissus were connected to the Greek mythological story. Havelock Ellis (1898) was the

first to evoke the Greek myth in psychological writings. Paul Näcke (1851–1913), a Russian-born German psychiatrist and director of an asylum at Colditz, Saxony, is first credited with introducing the term *narcissism* into psychiatry in 1899 in a study of sexual perversions, particularly excessive masturbation (Näcke, 1899). In this way, the instance of the Greek story of a young boy was generalized into a commonly recognized trait. A year before, Havelock Ellis, who was actively studying and writing on sexual matters, referred to excessive love as *narcissus-like* if it develops a self-love component. In fact, Näcke translated Ellis's paper into German, adding the "ism" to create the term *narcissism*. Ellis's (1898) paper described the case of women who become lost in self-admiration (symbolized by the mirror), which "appears to exist by itself, to the exclusion of any attraction for other persons" (p. 290). By 1927, Ellis had developed and summarized these views into a more complete paper on "the conception of narcissism," which he regarded as *autoeroticism*, or the self-absorption of sexual emotion into self-admiration. Ellis considered this to be a particular issue most likely found in young women as their consciousness of beauty develops, and indeed he considered the Greek god Narcissus to be quite feminine in characteristics in his youthfulness. It is interesting to speculate that the feminine components of Narcissus may have increased the attraction of Echo, in that they may have had a mirroring narcissistic reflection of her own beauty. Ellis's contribution beyond these conceptions is to further the pathological aspects of our understanding of narcissism. He extended this discussion into group psychology, explaining how "national narcissism" (patriotism and the hatred of foreigners) forms along similar lines. Similarly, "specific narcissism" glorifies humanity and mankind in triumphal narratives that contain narcissistic themes.

Ellis considered pathological narcissism to be a feature of specific persons, not a universal condition. Similarly, in 1911 Otto Rank published the first monograph on narcissism emphasizing the self-love and vanity aspects of the personality type. Rank discussed the phenomenon whereby a particular female can allow herself to love only after she has first established that her suitor loves her. Ellis, Rank, and Näcke confined their views to individuals or groups of individuals. These early uses of the term *narcissism* were illustrative in that it was used to describe behaviors of specific people. All that changed in 1914 with the publication of the highly significant and important paper "On Narcissism" (Freud, 1914/1957). Freud took the term and developed within it a thorough analysis of the possible causes of narcissism, the developmental aspects, its positive and potentially adaptive components, and negative components or effects. Within this paper, then, Freud introduced a sophisticated analysis of the underlying issues of the relationship between the self and others and of self-love and other-love.

FREUD'S ANALYSIS OF NARCISSISM

Freud (1914/1957) began "On Narcissism" by differentiating his views from his predecessors. He rejected the argument that masturbation or autoeroticism is necessarily related to the psychological term *narcissism*; he considered narcissism to be related to the development of the sense of self. Similarly, Freud differentiated narcissism from its more extreme form of megalomania, with the latter having more to do with omnipotent power and delusions of grandeur. He described narcissism as "libido that has been withdrawn from the external world has been directed to the ego and thus gives rise to an attitude which may be called narcissism" (p. 75). Freud did not pass judgement on self-love (or narcissism) in comparison with other-love (or anaclitic attachment based); his focus was on understanding these processes and choices and their consequences for mental health. Self-love can be both healthy and unhealthy:

A strong egoism is a protection against falling ill, but in the last resort we must begin to love in order not to fall ill, and we are bound to fall ill if, in consequence of frustration, we are unable to love. (p. 85)

Developmentally, it is healthy for young children to have self-love, especially as conveyed through the behaviors of parents, who provide the conditions for primary narcissism in their selfless care and admiration of their child. The development of healthy self-esteem (or ego) requires a degree of narcissism.

Freud extended this discussion by introducing not only self-love but also the need for love from others as confirming this narcissism. What is clear, therefore, is how such conditions can be heightened when people are themselves beautiful and charming, as was the Greek god Narcissus, with such processes applying equally to both males and females. Freud then considered both sides of these issues: first, the case of the narcissistic person who receives the confirming love of another and then, the effect on the loving other, who has to renounce some of their own narcissism in loving the other. In the case of mutual love, narcissistic and anaclitic processes are shared in equal measure:

The effect of dependence upon the loved object is to lower that feeling: a person in love is humble. A person who loves has, so to speak, forfeited a part of his narcissism, and it can only be replaced by his being loved. In all these respects self-regard seems to remain related to the narcissistic element in love. (p. 98)

In this analysis, Freud extended the understanding of narcissism by providing a more comprehensive context by which the processes can be both adaptive and pathological and an explanation for how these bear critically on the fate of love-relations with others. Freud also introduced possible variants

associated with narcissism: (a) loving oneself in the present; (b) loving what one once was; (c) loving what one hopes to become; or (d) loving someone who was once part of oneself. The echo subtype (which Freud terms the anaclitic attachment type) is preoccupied with feeding and protecting the overvalued other (p. 89).

Freud's development of the theory of these interpersonal processes helps us understand further the Greek myth. Narcissus invests his entire libido in himself, and Echo invests all her libido in Narcissus. She is therefore left empty (literally to disappear into the forest as a hollow voice), and he is left tortured and unwell, without the capacity to enter into a relationship with the thing he loves because it has no sustaining mutuality. In his conclusion, Freud hinted at a deeper analysis of narcissism, in relation to not only interpersonal relationships but also the broader impact on society, which in turn became the foundation for his later concepts of the superego and ego-ideal.

FURTHER DEVELOPMENT OF PATHOLOGICAL NARCISSISTIC SUBTYPES: 1926–1979

Many writers further developed the conceptualization of narcissism after Freud (Teicholz, 1978). A few examples are given. Clarke (1926) progressed the discussion of how to undertake psychotherapy with highly narcissistic patients when the ordinary transference neurosis does not operate. Reich (1933/1949) further developed the discussion of a particular type of male narcissism, characterized by arrogant and sadistic features that can be found in certain leaders, perhaps influenced by the emergence of hard-line military dictators in World War II. Fenichel (1945) extended this discussion to outline the vulnerabilities behind such personality types. Balint (1960) rejected the idea of a primary narcissism but developed a theory focussing on another component—the fate of libidinal impulses. For Balint, the individual is born in a state of intense relatedness to the environment biologically and libidinally. The trauma of birth accelerates the separation between individual and environment. Within these developments, love can become variously invested. Balint introduced the term *oncophilic* to describe the “echo” love relation, the overvaluation of love into another person and the consequent intense dependence on them. By contrast, the *philobatic* subtype describes the “narcissus” investment of love into the self, along the lines, described by Reich and Fenichel, of a loner with indifferent, deceitful, and untrustworthy characteristics.

Hendrick made a significant advance on the understanding of narcissism; his work was based on Freud's initial theoretical developments, the work of Murray (1964), and the earlier work of Balint and colleagues. Hendrick

(1964) expanded the interpersonal understanding of narcissistic relations, to further describe the "Echo" component, whereby a person with a very immature ego invests his or her libido wholly in another person and becomes dependent on that person for libidinal gratification. This person becomes the "ego ideal" just as Narcissus was the ideal for Echo. Hendrick deepened this discussion by referring to developmental processes. It is normal for a prepubescent child to invest love in another person (e.g., the parent), but in normal development that process is then displaced onto multiple others. The arrest of this process creates an unhealthy dependence on the idealized other. This dependence is then highly fragile and reliant on the consistency of the other to maintain the person's mental health. The death or loss of the idealized other creates a crisis whereby the person risks regressing to more primitive unsociable narcissism with its attendant psychopathology. Thus, when Narcissus dies, Echo is destroyed. Hendrick's discussion advances further our understanding of the fragility of the ego when the process sustaining it, in this case the idealization of another, is taken away.

Freud first introduced the relationship between narcissism and a healthy superego, but it was Kohut who further developed Freud's and Hendrick's ideas. Kohut (1966) extended the discussion into the function of narcissistic attitudes as both learning and growth extending opportunities. Narcissism through primary identifications with the mother and her struggles, and the healthy strivings in her life, presents new ideas of narcissistic processes as having a positive force if they move beyond primitive self-admiration. Similarly, he focused on the therapeutic situation, arguing that transforming narcissism into more healthy forms that serve society is preferable to simply trying to replace it with an alternative love object. In this way, he depathologized narcissistic processes and presented the emergence of the idealizing libido as a maturational step in development. In treatment, both idealizing and mirroring transferences can be present and can be transformed to assist the patient's progress.

Kohut (1966) discussed the healthy processes of idealization of parents at a critical stage in the child's development and explained how these processes provide a sense of security in the face of challenging developmental milestones. Kohut then moved on to discuss how the superego, the internalization of parental values, becomes established only when the narcissistic identification and idealisation of the parents diminishes, as the child disperses his or her identifications across a wider number of objects and internalized parental security. For healthy development to proceed, parents must also play a role in moderating their child's grandiosity. First, parents must support the grandiosity in order to enhance esteem. When positive self-regard has been internalized, they then need to qualify the grandiosity over time to develop maturity in the child. Failure to manage this process can lead to a

developmental arrest at the grandiose stage. At this arrested stage, there is an ongoing dependence on others to bolster the grandiosity. Therefore, the development of the narcissistic self is a maturational step.

For Kohut, premature interference with this maturational process may lead to narcissistic vulnerability, as the grandiose fantasy becomes repressed and inaccessible to modification. The person most likely to experience shame is the ambitious person who has a poorly integrated grandiose self-concept and an incapacity to empathize with the narcissism of others. The development of healthy narcissism, bound up in super-ego processes, becomes associated with self-esteem in the face of success, a healthy enjoyment of activities, and shame in the face of disappointments and failures. Creativity, empathy, capacity to contemplate impermanence, sense of humor, and wisdom are healthy transformations of narcissism, in that they moderate successes and failures in the interests of maintaining a healthy self-esteem. Kohut (1966) illustrated how dynamic these processes are. As an example, he cited the artist who alternates between productivity and satisfaction to a conviction that the work has no value. Humor and wisdom are seen as ways of mastering narcissistic demands and delusions, and thus Kohut (1971, 1977) moved his discussion into existential areas.

Kernberg (1970, 1972) explored the more extreme forms of narcissism, at the malignant antisocial or psychopathic level, and his explanation of these processes differed from that of Kohut. Kernberg referred to Freud's introduction of self-love and other-love and explained how psychopathology develops and manifests within this sphere. First, in its extreme form, narcissistic patients in psychotherapy are unable to experience the therapist as separate from themselves; rather, they see the therapist as an extension of themselves. Second, the independence of the therapist is resisted by patients' devaluation, spoiling, and depreciation of the therapist. It is critical that the therapist undo these attempts. Because insecurity and inferiority underlie grandiosity, the experience of a separate therapist may induce paranoia, suspiciousness, hatred, and envy. Over time, as differentiation is reinforced within the safety of therapy, the patient may experience guilt and despair for treating the therapist in such a way. Thus it is clear that in pathological narcissism, the ideal self, ideal object, and actual self become fused. In other words, the ego and superego, self and internalized values, are so insecure and unstable that they become fused into a grandiose self that projects unacceptable features into others. Kernberg's contribution to this development of ideas is the uncovering of the therapeutic implications of extreme narcissism and his discovery that underneath insecurity may be a rage and aggression expressed toward others (and sometimes the self). Thus, Kernberg (1975) brought into focus the primitive conflicting and splitting forces of aggression and libido, frustration and gratification, bad and good,

as they are in Kleinian British object relations theory (Klein, 1952; Mendez, Fine, & Guntrip, 1976).

There is an extensive literature on the differences between Kohut and Kernberg's views (Adler, 1986). It is possible that their work describes different subtypes of narcissism, possibly emerging in part from the different settings they collected their data. Kohut discussed in particular a "merger self-object transference" that may align more with the role of Echo. In contrast, Kernberg discussed the "self-sufficient transference," which may be more like the role of Narcissus. Both authors emphasized the difficulties for the therapist in managing these patients: Both the Echo and Narcissus types can stir up in the therapist difficulties with tolerating boredom in the therapy, managing idealization by the patient, and handling aggression and devaluation by the patient.

Returning to Freud, what is clear is that the Narcissus and Echo processes are best understood within the bounds of the patient's seeming choices on how to tolerate insecurities, and therefore both types of behaviors may be present in the same patient at different times. Such issues bear upon the development of the concept of narcissism, since these debates began in the 1970s and 1980s (Cain et al., 2008). The emergence of new tools and measures has emphasized the importance of considering dimensional understandings rather than just categorical differences. In this way, the ancient Greek story of Narcissus and Echo may be less about actual persons than different psychological processes. Nevertheless, it is remarkable that such ancient myths continue to hold an important place in our understanding of contemporary psychology.

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2

DEFINING NARCISSISTIC SUBTYPES

ERIC RUSS AND JONATHAN SHEDLER

Despite its severity and stability (Blais, Hilsenroth, & Castlebury, 1997; Perry & Perry, 2004), narcissistic personality disorder (NPD) is one of the least-studied personality disorders. The available research focuses on narcissism as a unitary disorder, but a recent body of research has emerged on subtypes of narcissism. We begin this chapter with a description of the evolution of the diagnosis of narcissism and the limitations of the current approach. We explain why attention to subtypes of NPD deepens our understanding of the diagnosis. Finally, we describe a program of research to identify empirically derived and clinically useful subtypes of NPD.

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Understanding and Treating Pathological Narcissism, J. S. Ogrodniczuk (Editor)

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DEVELOPMENT OF THE CURRENT NPD CRITERIA

The manner in which NPD is conceptualized has a significant impact on research and treatment. The approach we take to describing NPD influences the questions we ask to assess the disorder and the way we design our treatments and measure therapeutic change. Given these high stakes, it may be helpful to consider ways to improve current diagnostic criteria. A more detailed understanding of the empirical literature on NPD can help improve the new diagnostic system for personality disorders that will be presented in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2011; Shedler et al., 2010). Before we discuss how we think the current system can be improved, we briefly describe the evolution of the diagnosis of narcissism over time. (For a more thorough description, see Chapter 1 in this volume.)

Freud (1914) first developed the concept of narcissism almost a century ago. He described narcissistic self-love as a normal part of the development of a sense of self, which could become pathological if this normal developmental process was disrupted.

The major theoretical advances in the concept of narcissism occurred in the 1960s and 1970s with the clinical theories of Heinz Kohut (1971) and Otto Kernberg (1975). Although both considered narcissism to be a disorder of self-esteem regulation, they disagreed about developmental trajectories and etiology. Kohut conceptualized narcissistic patients as developmentally arrested in a normal stage of infantile narcissism. He argued that over the course of normal development, before the development of conscience, a child is entirely self-focused. Normally, an empathic caregiver provides recognition and validation (“mirroring”), which helps the child develop both the capacity for self-esteem regulation and a functioning conscience (by internalizing parental standards). Failure to help the child regulate self-esteem leaves the child prone to swings in self-evaluation and particularly to a grandiosity that reflects a deficit in internalized regulatory functions (Kohut, 1966, 1971).

In contrast, Kernberg’s (1998) theory emphasized a disruption in representations of self and others caused by parents who are at once both cold and rejecting and admiring. According to Kernberg, narcissistic individuals maintain a sense of self by locating “good” in themselves and projecting “bad” outward. Both their views of themselves and their ego ideal or ideal self are grandiose; they create standards for the self that are impossible to reach and hence they need to distort their self-representations in a correspondingly grandiose direction. Projection of “bad” attributes onto others, according to Kernberg, leads narcissistic individuals to devalue others and may result in explosive rage at others (Kernberg, 1975, 1989, 1998).

Whether narcissistic rage is diagnostic, and if so, what elicits it, are open questions. Morrison argued (1983, 1999) that the rage sometimes seen in NPD patients is actually preceded by a moment of (usually unconscious) shame. This shame is psychologically overwhelming and is instead defended against by excessive pride (grandiosity). Some NPD patients do not seem to experience much shame and might be motivated more by pride than shame (Campbell, Foster, & Brunell, 2004). It is possible that Kernberg's description more closely fits those motivated by shame, whereas Kohut's description fits those motivated by pride. In fact, Kernberg and Kohut may have been describing two qualitatively different types of narcissistic patients (Gabbard, 1998; McWilliams, 1994).

Millon (1969, 1998) led the transition of clinical formulations by psychoanalytic theorists into the formalized criteria for NPD in the third edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III)* (American Psychiatric Association, 1980; see Chapter 3, this volume, for a historical account of NPD in the DSM). These criteria largely stayed the same in the third revised edition of the DSM (*DSM-III-R*; American Psychiatric Association, 1987), although the approach to diagnosing NPD, as in the rest of the diagnostic manual, shifted from a mixed polythetic–monothetic system to a purely polythetic system (i.e., instead of requiring several criteria related to grandiosity plus two among a list of interpersonal criteria, the selection of five of nine criteria from a single list was sufficient). The *DSM-III* and *DSM-III-R* criteria describe a person with a grandiose sense of self-importance and preoccupation with fantasies of unlimited success. The narcissist described in the *DSM-III* and *DSM-III-R* lacks empathy and experiences feelings of rage, shame, or humiliation when criticized.

Although this initial formulation provided a common set of criteria for research, it was not empirically derived, and the NPD diagnosis showed significant diagnostic overlap with other personality disorders (Gunderson, Ronningstam, & Smith, 1995). Ronningstam and Gunderson (1990) sought to address this diagnostic overlap by investigating which criteria best differentiated NPD patients from other patient groups. They developed the *Diagnostic Interview for Narcissism* (Gunderson & Ronningstam, 1987; Gunderson, Ronningstam, & Bodkin, 1990) to evaluate the *DSM-III-R* criteria. Their results indicated that statements about grandiosity, interpersonal relations (e.g., exploitiveness), and high or low achievement were highly discriminating of NPD (Ronningstam & Gunderson, 1989). Largely as a result of this study, the fourth edition of the DSM (*DSM-IV*; American Psychiatric Association, 1994) added the criterion “shows arrogant, haughty behaviors or attitudes” and eliminated the criterion “reacts to criticism with feelings of rage, shame or humiliation.” Ronningstam and Gunderson (1990) noted that the patients they interviewed still possessed these reactive characteristics;

however, the characteristics did not discriminate narcissists from other patients. The decision to delete a characteristic feature of the disorder might reduce comorbidity, but it raises thorny questions about whether doing so omits important elements of the construct and presents a clinically inaccurate, or at least incomplete, portrait.

The evolution of NPD criteria from clinical descriptions to largely behavioral symptoms reduced comorbidity but sheds little light on underlying personality processes that tend to be the target of effective treatments. Additionally, the current system of choosing five of nine criteria allows for a heterogeneous presentation of the disorder with 126 possible symptom combinations to meet criteria and the possibility that two people diagnosed with NPD may overlap on only one symptom. Overall, the transition from early clinical conceptualizations to the current DSM diagnosis has led to the construction of DSM criteria for NPD that both allows for substantial heterogeneity and underemphasizes aspects of personality and internal functioning that are central to the disorder.

To illustrate the limitations of the current diagnostic criteria, we describe here a study from our group that suggests a broader conceptualization of NPD. Westen and Shedler (1999b) asked a random national sample of psychologists and psychiatrists to provide descriptions of a patient with a given personality disorder using a psychometric instrument designed for use by clinically experienced observers, the Shedler-Westen Assessment Procedure 200 (SWAP-200; Westen & Shedler, 1999b). The SWAP-200 is a personality assessment instrument that asks informants to sort 200 statements about personality according to their descriptiveness, from least descriptive to most descriptive. (SWAP-200 software is available for download at <http://www.SWAPassessment.org>.) We focus here on the results for NPD ($n = 40$).

SWAP-200 items that had the highest mean ratings across NPD patients included DSM-IV criteria but also additional interpersonal and intrapersonal criteria, including an item written to reflect the criterion deleted from DSM-IV ("Reacts to criticism with feelings of rage, shame or humiliation") as well as "Tends to be angry or hostile (whether consciously or unconsciously)," "Tends to blame others for own failures and shortcomings," "Tends to be controlling," "Tends to be critical of others," "Tends to get into power struggles," "Tends to be competitive with others," and "Tends to feel misunderstood, mistreated, or victimized" (Westen & Shedler, 1999a). Additionally, the investigators used Q-factor analysis to derive diagnoses independent of DSM criteria. (Q-factor analysis is an inverted factor analysis in which people rather than items are factored and hence grouped together, yielding diagnostic configurations.) An empirically derived NPD diagnosis emerged, which once again included the DSM-IV criteria but also included several additional items, many of which (as was the case with the empirical description of NPD

patients as defined in *DSM-IV*) were more central to the construct quantitatively than many *DSM-IV* criteria: “Reacts to criticism with feelings of rage, shame or humiliation” “Tends to be competitive,” “Lacks close friendships,” “Expects self to be perfect,” “Tends to be self-critical,” “Appears afraid of commitment to a long-term love relationship,” and “Seeks to be the center of attention” (Westen & Shedler, 1999b). These aspects of narcissistic personality could be included in future iterations of the diagnostic manual. However, improving the diagnostic criteria in this way does not fully address the problem of heterogeneity—that is, the existence of distinct personality subtypes within the diagnosis of NPD.

NARCISSISTIC SUBTYPES

An emerging literature from several research groups supports the clinical hypothesis that two distinct types of narcissism exist: grandiose and vulnerable (Dickinson & Pincus, 2003; Gabbard, 1989, 1998; Gersten, 1991; Pincus & Lukowitsky, 2010; Pincus, Lukowitsky, & Wright, 2010; Revik, 2001; Smolewska & Dion, 2005; Wink, 1991). The *grandiose* subtype can be described as “grandiose, arrogant, entitled, exploitative, and envious”; the *vulnerable* subtype is characterized as “overly self-inhibited and modest but harboring underlying grandiose expectations for oneself and others” (Dickinson & Pincus, 2003, pp. 188–189). Criterion validity of these subtypes has been suggested by research comparing subtypes on various measures independent of those used for subtyping. For example, the vulnerable subtype tends to report insecure attachment styles by self-report, whereas the grandiose subtype reports a more secure attachment style (Dickinson & Pincus, 2003; Smolewska & Dion, 2005). Though highly suggestive, a significant limitation of such studies is their heavy reliance on self-report questionnaires. In fact, it seems unlikely that either subtype has secure attachment relationships, given the interpersonal characteristics attributed to narcissists by observers (Klonsky, Oltmanns, & Turkheimer, 2002).

In fact, almost all previous subtyping approaches have to rely on self-report measures of narcissism, either scales of self-report personality questionnaires such as the Minnesota Multiphasic Personality Inventory or narcissism questionnaires such as the Narcissistic Personality Inventory. However, studies comparing self-report to other-report suggest that narcissistic individuals do not provide accurate self-descriptions (Klonsky, Oltmanns, & Turkheimer, 2002), suggesting the need for alternative methods. Indeed, the notion of studying NPD by relying on the self-descriptions of narcissistic individuals (for whom lack of insight and distorted self-perceptions are diagnostic) is inherently problematic.

A NEW DIRECTION FOR NPD SUBTYPING

Research from our group offers an alternative to relying on self-reports. We describe here a follow-up to the SWAP-200 study just described. Using an updated version of the SWAP-200 instrument, we developed empirically derived NPD subtypes that describe variations in NPD presentation commonly seen in clinical practice. This approach has the advantage of making diagnosis more clinically meaningful without sacrificing the important empirical gains made over the past 20 years.

As part of a larger National Institute of Mental Health–funded study examining personality pathology, a national sample of clinicians reported on a randomly selected patient. Clinicians completed the Shedler-Westen Assessment Procedure-II (SWAP-II). The SWAP-II is the latest version of the SWAP-200, which has been used in a number of taxonomic studies (Shedler & Westen, 2004a, 2004b; Westen & Shedler, 1999a, 1999b).

The SWAP-II item set subsumes Axis II criteria included in *DSM-III* and *DSM-IV*. Additionally, it incorporates selected Axis I criteria relevant to personality (e.g., anxiety, depression), personality constructs described in the clinical and research literatures over the past 50 years, and clinical observations from pilot studies. The original SWAP-200 item set was the product of a 7-year iterative item revision process; similarly, the SWAP-II was revised to accommodate new findings, clarify existing item content, and minimize item redundancy. A growing body of research supports the validity and reliability of the adult and adolescent versions of the SWAP-II in predicting a wide range of external criteria, such as suicide attempts, history of psychiatric hospitalizations, ratings of adaptive functioning, interview diagnoses, and developmental and family history variables (e.g., Westen & Muderrisoglu, 2003, 2006; Westen & Shedler, 1999a; Westen, Shedler, Durrett, Glass, & Martens, 2003; Westen & Weinberger, 2004).

We selected patients from the larger data set diagnosed with NPD ($N = 101$) and applied Q-factor analysis to their SWAP profiles. Q-factor analysis is computationally identical to conventional factor analysis except that people rather than items are factored and hence grouped together. We retained three Q-factors interpretable as subtypes (see Exhibit 2.1; for further methodological detail, see Russ, Shedler, Bradley, & Westen, 2008). Each subtype showed distinct patterns of correlations with external criterion variables. These included comorbidity with Axis I and Axis II disorders, measures of adaptive functioning, and etiological variables. Additionally, the subtypes showed low to moderate correlations ($r = -.01-.35$) with each other. Taken together, this suggests that we have identified three distinct subtypes of narcissists, although we do not assume that these subtypes are categorical. Because the aggregation of data over 100 individuals (necessary for reliability) minimizes individual

EXHIBIT 2.1

Q-Factors: Subtypes of Narcissism

Q-Factor 1: Grandiose/Malignant Narcissist

- Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).
- Appears to feel privileged and entitled; expects preferential treatment.
- Has little empathy; seems unable or unwilling to understand or respond to others' needs or feelings.
- Tends to blame own failures or shortcomings on other people or circumstances; attributes his/her difficulties to external factors rather than accepting responsibility for own conduct or choices.
- Tends to be critical of others.
- Tends to be controlling.
- Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).
- Has little psychological insight into own motives, behavior, etc.
- Tends to get into power struggles.
- Tends to be angry or hostile (whether consciously or unconsciously).
- Takes advantage of others; has little investment in moral values (e.g., puts own needs first, uses or exploits people with little regard for their feelings or welfare, etc.).
- Tends to be dismissive, haughty, or arrogant.
- Tends to seek power or influence over others (whether in beneficial or destructive ways).
- Tends to hold grudges; may dwell on insults or slights for long periods.
- Tends to be manipulative.
- Tends to feel misunderstood, mistreated, or victimized.
- Is prone to intense anger, out of proportion to the situation at hand (e.g., has rage episodes).
- Experiences little or no remorse for harm or injury caused to others.

Q-Factor 2: Fragile Narcissist

- Tends to feel unhappy, depressed, or despondent.
- Tends to be critical of others.
- Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).
- Tends to be angry or hostile (whether consciously or unconsciously).
- Tends to feel anxious.
- Tends to feel envious.
- Is prone to painful feelings of emptiness (e.g., may feel lost, bereft, abjectly alone even in the presence of others, etc.).
- Tends to fear s/he will be rejected or abandoned.
- Tends to be competitive with others (whether consciously or unconsciously).
- Tends to have extreme reactions to perceived slights or criticism (e.g., may react with rage, humiliation, etc.).
- Tends to feel misunderstood, mistreated, or victimized.
- Lacks close friendships and relationships.
- Tends to ruminate; may dwell on problems, replay conversations in his/her mind, become preoccupied with thoughts about what could have been, etc.
- Is articulate; can express self well in words.
- Tends to feel like an outcast or outsider.
- Appears to feel privileged and entitled; expects preferential treatment.

(continues)

EXHIBIT 2.1

Q-Factors: Subtypes of Narcissism (Continued)

Tends to feel s/he is inadequate, inferior, or a failure.
Is self-critical; sets unrealistically high standards for self and is intolerant of own human defects.

Q-Factor 3: High Functioning/Exhibitionistic Narcissist

Has an exaggerated sense of self-importance (e.g., feels special, superior, grand, or envied).
Is articulate; can express self well in words.
Appears to feel privileged and entitled; expects preferential treatment.
Enjoys challenges; takes pleasure in accomplishing things.
Tends to be energetic and outgoing.
Tends to be competitive with others (whether consciously or unconsciously).
Seeks to be the center of attention.
Is able to use his/her talents, abilities, and energy effectively and productively.
Seems to treat others primarily as an audience to witness own importance, brilliance, beauty, etc.
Tends to seek power or influence over others (whether in beneficial or destructive ways).
Is able to assert him/herself effectively and appropriately when necessary.
Tends to be controlling.
Finds meaning and satisfaction in the pursuit of long-term goals and ambitions.
Has fantasies of unlimited success, power, beauty, talent, brilliance, etc.
Tends to be critical of others.
Appears comfortable and at ease in social situations.
Has a good sense of humor.
Tends to be sexually seductive or provocative (e.g., may be inappropriately flirtatious, preoccupied with sexual conquest, prone to "lead people on," etc.)

Note. From "Refining the Construct of Narcissistic Personality Disorder: Diagnostic Criteria and Subtypes," by E. Russ, J. Shedler, R. Bradley, & D. Westen, 2008, *The American Journal of Psychiatry*, 165, p. 1477. Copyright 2008 by the American Psychiatric Association. Reprinted with permission.

differences, we suggest that these subtypes be conceptualized as prototypes that any individual NPD patient may fit to a greater or lesser degree. The descriptions of the three subtypes that follow are based on the SWAP-II items that make up the subtype as well relevant external criterion variables.

We labeled the first subtype *grandiose/malignant narcissism*. This subtype is similar to the grandiose type found in previous research but with the important difference that the grandiosity appears to be more elemental and less defensive. Grandiose/malignant narcissistic individuals lack empathy, externalize blame, and react harshly when criticized. This subtype represents an aggressive narcissistic style with a seething anger or rage, interpersonal manipulateness, an exaggerated sense of self-importance, and feelings of privilege. Individuals with this condition tend not to experience underlying feelings of inadequacy or to be prone to negative affect states other than anger. They have little insight into their own behavior and tend to blame

others for their problems. This differs from some previous descriptions, which have described grandiose narcissistic individuals as merely being more successful at covering their inadequacy. Grandiose/malignant narcissists shares features with individuals with antisocial personality disorder and paranoid personality disorder and also tend to have comorbid substance use disorders. This subtype is characterized by externalizing behaviors such as fighting or being the perpetrator in an abusive relationship. Finally, the grandiose/malignant subtype is the most likely to have displayed externalizing behavior as a child, including setting fires and torturing animals.

The second subtype, labeled *fragile narcissism*, is similar to the vulnerable type found in previous research (Pincus & Lukowitsky, 2010). Fragile narcissists feel both grandiose and inadequate, suggesting an alternation of representations of self, defensive grandiosity, or a grandiosity that emerges under threat. These grandiose self-representations seem to aid in averting feelings of inadequacy, smallness, anxiety, and loneliness. They want to feel important and privileged, and when the defense is operating effectively, they do. However, when the defense fails, they have a powerful current of negative affect that brings out feelings of inadequacy, often accompanied by rage. Fragile narcissists shares features with individuals with borderline personality disorder, avoidant personality disorder, and dependent personality disorder. Compared with the other narcissism subtypes, people in this subtype had the worst adaptive functioning; they had the most difficulty in work settings and in interpersonal relationships.

We labeled the third subtype *high functioning/exhibitionistic narcissism*, reflecting the fact that individuals with high loadings on this Q-factor are grandiose, self-centered, and competitive and feel entitled, but they also have a number of healthy characteristics; they are articulate, energetic, interpersonally comfortable, and achievement oriented. The high functioning/exhibitionistic narcissist is not well represented in previous research literature but is well represented in the clinical literature (e.g., Westen, 1990). Patients who match this subtype have an exaggerated sense of self-importance and feelings of privilege but are also articulate, energetic, and outgoing. They tend to show surprisingly good adaptive functioning relative to the other subtypes, and their narcissism motivates them to succeed. As expected, people in this subtype, although not free from pathology, tend to do reasonably well in their lives.

One question frequently raised about person-centered (typological or prototypal) approaches to diagnosis is the extent to which they can be reduced to their constituent traits. The subtypes identified here differed considerably in their trait profiles. Grandiose/malignant narcissism was strongly associated with most of the NPD traits we identified, particularly the Psychopathy and Hostility factors. Fragile narcissism was moderately associated with the Psychopathy and Emotional Reactivity factors and negatively associated with

the Hostility factor. These associations suggest the importance of assessing and understanding narcissistic features across the personality disorders, particularly Cluster B. High functioning narcissism was strongly associated with the Grandiosity factor, suggesting the relatively “pure” grandiosity of this group. However, careful examination of the subtypes in terms of their underlying trait structure does not suggest a ready reproducibility of the subtypes from the traits. Rather, they seem to provide different levels of analysis, with the subtypes identifying distinct, clinically meaningful constellations, with grandiose/malignant narcissism on the border with psychopathy, fragile narcissism describing a kind of defensive retreat into grandiosity, and high functioning narcissism associated with a less limited capacity to love and work.

IMPLICATIONS FOR TREATMENT

In addition to phenomenological differences, it is likely that these subtypes would respond differently to psychotherapy and potentially to medication. As part of the study described in the preceding section, we also collected exploratory treatment data, asking clinicians to rate the effectiveness of their treatment with each patient. Clinicians reported that grandiose/malignant narcissistic patients were the least responsive to treatment. Given the features of this subtype, such patients are likely to be difficult to work with. Because they lack the vulnerability of the other subtypes, grandiose/malignant narcissistic patients are likely to have little motivation to seek out or work in psychotherapy. They would be more likely to attempt to manipulate their clinician or attempt to establish dominance in the room. Fragile narcissistic patients may be better suited for psychotherapy. They would likely benefit from interventions focused on acknowledging both sides of their fundamental narcissistic conflict, grandiose feelings and the underlying vulnerability that drives them. Because fragile narcissist patients may be less aware of their vulnerability, they may require the clinician’s help to tolerate feelings of vulnerability without resorting to grandiosity or devaluation of others. Finally, high functioning/exhibitionistic narcissistic patients might benefit from an interpretive, insight-oriented approach to help them become more aware of their narcissistic defenses and increase the potential for meaningful relationships. (Issues of transference and countertransference are explored in more detail in Chapter 12, this volume.)

CASE VIGNETTES

In this section, we describe case vignettes to better illustrate these distinctions. Patient identities have been disguised to maintain confidentiality.

A Grandiose/Malignant Narcissist Patient

M. is a 46-year-old divorced man with an Axis I diagnosis of alcohol abuse. He is in his 12th month of treatment at a residential treatment facility. M. has a history of arrests for fighting and domestic violence and has difficulty holding a job because of interpersonal conflicts in the workplace. M.'s parents, who were alcoholic, divorced when M. was 3 years old, and M. was raised by a succession of relatives. On the SWAP-II, M. is described as self-important, privileged, entitled, arrogant, lacking empathy, and disdainful of others. He appears to believe that conventional rules of conduct do not apply to him. He seeks to be the center of attention, treats others primarily as an audience, and appears to believe that he should associate only with people who are high-status or otherwise "special." He is prone to intense anger and blames others for his difficulties. M.'s clinician described therapy as completely ineffective to date.

A Fragile Narcissist Patient

F. is a 34-year-old married man with an Axis I diagnosis of major depressive disorder, who has been treated for 9 months in a private practice setting. He comes from an upper middle class background, holds a master's degree in his field, and has been continuously employed. F.'s parents divorced when he was 14 years old. As described by the SWAP-II, F. presents with a mix of seemingly contradictory attributes, with features of grandiosity coexisting with feelings of inadequacy and vulnerability. F. has an exaggerated sense of self-importance and appears to feel privileged and entitled. He expects preferential treatment and has fantasies of unlimited success, power, beauty, talent, and brilliance. For example, he spends much of his day imagining what he would do and say to his coworkers if he was in charge of his company. He lacks empathy and seems unable or unwilling to understand or respond to others' needs or feelings unless they coincide with his own. F. also feels unhappy, depressed, and despondent, and he finds little pleasure or satisfaction in life's activities. Interpersonally, F. tends to be critical of others, angry, hostile, oppositional, or contrary. He tends to hold grudges and to have conflicts with authority figures. At the same time, F. feels envious of others; tends to feel misunderstood, mistreated, or victimized; and tends to feel helpless and powerless. F.'s clinician rated therapy as somewhat effective to date.

A High Functioning/Exhibitionistic Narcissist Patient

E. is a 58-year-old man, currently separated, who has been treated for 16 months in a private practice setting. He has Axis I diagnoses of anxiety

disorder no other symptom and adjustment disorder. He is employed and working to his full potential. As described by the SWAP-II, E. is psychologically insightful, tends to be energetic and outgoing, appears comfortable and at ease in social situations, is articulate, and has a good sense of humor. However, E. also has an exaggerated sense of self-importance. He appears to feel privileged and entitled and expects preferential treatment. He seeks to be the center of attention, expresses emotion in exaggerated and theatrical ways, and seems to treat others primarily as an audience to witness his own importance, brilliance, beauty, and so on. E. is also highly self-critical; he sets unrealistically high standards for himself and is intolerant of his own defects. He tends to feel envious of others and competitive with others, and he can be dismissive, haughty, or arrogant. E.'s clinician rated therapy as mostly effective.

DISCUSSION

Our approach to subtyping narcissistic personality using the SWAP-II has several advantages over prior approaches. By recruiting through a national practice network, we were able to gather data on a large number of patients diagnosed with NPD. Additionally, the use of quantified clinical judgment gives this approach several advantages over previous research. Most important, it allowed us to avoid the problem of relying on narcissistic individuals to report their own symptoms, which they generally cannot do. In addition, clinical and social psychological theory and research on narcissism have largely occurred in separate literatures, and the methodological approach described above allowed us to cross some of those boundaries.

Although the subtypes discussed above were developed from empirical, theory-blind research, they correspond well with the subtypes of narcissistic personality described in the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006; see Chapter 4, this volume). The PDM describes "arrogant/entitled" and "depressed/depleted" variants of narcissism, which roughly correspond to our grandiose/malignant and fragile types, respectively. The PDM also captures our high functioning/exhibitionistic type by noting that each personality disorder has a less disturbed variant that may be considered a personality *pattern* or *style* rather than a "disorder."

Finally, the research discussed above suggests the construct of narcissism may be a more complex construct than portrayed by *DSM-IV*. In addition to improving the current diagnostic criteria, it may be helpful for future editions of the manual to describe the grandiose/malignant, fragile, and high functioning/exhibitionistic subtypes of NPD. These subtypes reflect a more nuanced, empirically derived understanding of NPD that may help bridge the gap between empirically and clinically derived concepts of narcissistic pathology.

(DSM-IV; American Psychiatric Association, 1994). Next, we briefly introduce alternate systems for categorizing narcissism, such as the *International Classification of Diseases* (10th ed.; ICD-10; World Health Organization, 1992); behavioral approaches; and the *Psychodynamic Diagnostic Manual* (PDM; Psychodynamic Diagnostic Manual Task Force), which is expanded on in Chapter 4, this volume. We conclude with a discussion of the proposed changes for DSM-5 (American Psychiatric Association, 2011b), including the rationale for and critique of these changes.

A BRIEF HISTORY OF THE DSM

In 1935, the American Psychiatric Association developed a diagnostic system based on Kraepelin's (1899/1990, 1913/1971, 1913/1976) influential textbooks. This systematic approach to mental disorders was based on case studies and was less relevant for acute conditions, thus leading hospitals to develop their own systems, which were often discordant and created communication difficulties. The first edition of the DSM (American Psychiatric Association, 1953), an effort to standardize the diagnostic systems, was a glossary describing 108 diagnostic categories based on Adolf Meyer's developmental psychobiologic views, many of which were described as reactions to environmental conditions that could result in emotional problems. The second edition (DSM-II; American Psychiatric Association, 1968) specified 182 different disorders and distinguished between neurotic and psychotic disorders. Except for the description of neuroses, which were strongly influenced by psychodynamic thought, DSM-II did not provide a theoretical framework for understanding nonorganic mental disorders; it was based on the best clinical judgment of a committee of experts and its consultants (Widiger, Frances, Pincus, Davis, & First, 1991). Narcissism or narcissistic personality disorder (NPD) was not an official diagnosis in either the first or the second edition of the manual.

Beginning around 1970, clinical investigators in the United States began to feel increasing dissatisfaction with the imprecision of psychiatric diagnostic criteria. This culminated in the publication of DSM-III in 1980, which provided a detailed lexicon or taxonomy that established common definitions of various psychopathological states that now enabled investigators and clinicians to have greater consistency (reliability) in their diagnoses.

DSM-III attempted to establish a "multi-axial, theoretically neutral system" that placed a wide range of descriptive symptoms into 265 separate categories or disorders. In attempts "to resolve various diagnostic issues, the task force relied, as much as possible, on research evidence relevant to various kinds of diagnostic validity" (American Psychiatric Association, 1980, p. 3). Concepts of reliability and validity from the psychometric tradition within psychol-

ogy were influential in shaping the organization of *DSM-III*. Extensive field trials were conducted to deal with unacceptable levels of reliability (Spitzer & Fleiss, 1974). Because of the lack of sufficient research, however, the committee deliberations were often “unstructured” and “many decisions continued to be based primarily on the best clinical judgment and experience of the committee members” (Widiger et al., 1991, p. 281). The task force attempted to remain theoretically neutral in its deliberations so as to create an atheoretical nomenclature that could be used broadly by clinicians of various orientations.

The *DSM-III* task force used primarily descriptive symptom criteria to create a multi-axial diagnostic classification system, separating personality disorders (Axis II) from clinical syndromes (Axis I). The classificatory system was *polythetic* (Millon, 1991), meaning that not all symptoms or diagnostic criteria for a given disorder were necessary for making a diagnosis. Thus, the classificatory system created prototypic descriptions of particular disorders on the basis of a cluster of symptoms, and these became the concrete signs of discrete categories. Because there were “many instances in which the criteria were not entirely clear, were inconsistent across categories, or were even contradictory” (American Psychiatric Association, 1987, p. xvii), the American Psychiatric Association revised *DSM-III* in 1987 (*DSM-III-R*); field trials were used to establish concurrent and descriptive validity of “clinicians’ diagnoses . . . rather than simply [addressing] . . . the reliability of the diagnoses” (Widiger et al., 1991, p. 282).

CLINICAL MODELS OF THE CONCEPT OF NARCISSISM

NPD was first introduced into the official diagnostic system with *DSM-III*, owing to the widespread use of the concept by clinicians and the writings of Kernberg, Kohut, and Millon. Kernberg (1967) and Kohut’s (1968) writings on narcissism were, in part, a reaction to increased clinical interest in treating these patients. Their papers, in turn, stimulated increased clinical interest in the concept. However, these clinical trends also paralleled trends in critical social theory (Adorno, 1967; Lasch, 1979; Marcuse, 1955; Wolfe, 1977) as well as the identification of narcissism as a personality factor in a number of social psychological studies (Block, 1971; Eysenck & Eysenck, 1975; Murray, 1938; Raskin & Hall, 1979; see also Frances, 1980).

In Kernberg’s (1975, 1984) view, narcissism develops as a consequence of parental rejection, devaluation, and an emotionally invalidating environment. The child copes with parents who are inconsistent in their investment or who relate only in order to satisfy their own needs by defensively withdrawing and forming a pathologically grandiose self-representation. By combining aspects of the real self with fantasized aspects of what the child wants

to be, as well as fantasized aspects of an ideal, loving parent, the grandiose self serves as an internal refuge from the harsh and depriving environment. The negative self-representation of the child is disavowed and not integrated into the grandiose representation, which is the seat of agency from which the narcissist operates. This split-off unacceptable self-representation can be seen in the emptiness, chronic hunger for admiration and excitement, and shame that also characterize the narcissist's experience (Akhtar & Thomson, 1982).

In contrast, Kohut (1971, 1977) viewed pathological narcissism as a normal developmental process gone awry. For Kohut, childhood grandiosity is normal and can be understood as a process by which the child attempts to identify with and become like his idealized parental figures by taking on attributes of perceived competence and power. In normal development this early grandiose self becomes modulated and eventually contributes to an integrated sense of self, with realistic ambitions and goals. However, if not properly modulated, what follows is the failure of the grandiose self to be integrated into the individual's whole personality. Others are taken as extensions of the self (Kohut's term is *selfobject*) and are relied upon to regulate one's self-esteem and anxieties regarding a stable identity. Because narcissistic individuals are unable to sufficiently manage the normal fluctuations of daily life and its affective correlates, other people are unwittingly relegated to roles of providing internal regulation for them (by way of unconditional support, admiration, and total empathic attunement), the same way a parent would provide internal regulation for a young child.

In contrast to Kernberg and Kohut, Millon (1981) articulated an evolution-based social learning theory of narcissism. Millon (1981) postulated that narcissism develops not as a response to parental devaluation but rather as a consequence of parental overvaluation. According to Millon (1981), as a child the narcissistic individual is treated as a special person, given much attention, and led by parents to believe that he or she is perfect. Millon (1981) contended that such unrealistic overvaluation leads to self-illusions that "cannot be sustained in the outer world" (p. 165). According to Millon, firstborn and only children are more vulnerable to narcissism because they tend to receive an abundance of attention and special treatment. However, the evidence is mixed regarding birth order, and there is no evidence that only-child status is related to narcissism.

INTRODUCTION OF NARCISSISM TO THE DSM-III

A committee of psychiatrists and psychologists developed the DSM-III definition of NPD and its criteria by consensus from a summary of the pre-1978 literature, without the benefit of empirical evaluation by clinical study

groups. The criteria represented amalgamations of the theoretical and clinical work of Kernberg, Kohut, and Millon, with “expert” input (see Frances, 1980, for a description). *DSM-III* criteria for NPD included the following characteristics:

1. a grandiose sense of self-importance or uniqueness;
2. preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love;
3. exhibitionism (seeking of constant attention and admiration); and
4. cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness in response to criticism, indifference to others, or defeat.

At least two of the following disturbances in interpersonal relationships were required for the diagnosis:

1. entitlement (expectations of special favors);
2. interpersonal exploitativeness;
3. alternations between extreme overidealization and devaluation in relationships; or
4. lack of empathy.

A number of the *DSM-III* NPD criteria (e.g., cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness in response to criticism; indifference to others or defeat; and vacillation between idealization and devaluation) captured both the dynamic and defensive nature of narcissism proposed by the early psychoanalytic writers as well as Kernberg and Kohut’s later writings. In addition, the description of NPD noted that “frequently the sense of self-importance alternates with feelings of special unworthiness” (p. 315) and “self-esteem is often fragile; the individual may be preoccupied with how well he or she is doing and how well he or she is regarded by others” (American Psychiatric Association, 1980, p. 316). As Cain, Pincus, and Ansell (2008) noted, the criteria in *DSM-III*, although not explicit, “assumed an underlying insecurity that was often, but not always, compensated for by overt grandiose behaviors” (p. 647).

The criteria for NPD in *DSM-III-R* (American Psychiatric Association, 1987) followed the criteria for *DSM-III* rather closely. However, the disorder was changed from a mixed polythetic–monothetic category to an entirely polythetic one. The interpersonal criteria, which had originally included four parts (entitlement, exploitativeness, alternating between idealization and devaluation, and lack of empathy), were reduced to three parts, with “alternating between idealization and devaluation” eliminated. The criterion that included both grandiosity and uniqueness was split into two

separate criteria, and a criterion addressing preoccupation with feelings of envy was added. These changes resulted in a greater emphasis on grandiose themes and criteria (Cain et al., 2008; Gunderson, Links, & Reich, 1991; Gunderson, Ronningstam, & Smith, 1995). Additionally, Morey (1988), in a survey of 170 clinicians reporting on 291 patients, found that the changes in criteria and cutoff points between *DSM-III* and *DSM-III-R* resulted in a 350% increase in the number of patients meeting criteria for NPD (from 6% to 22%). However, it is unclear from epidemiological studies whether these criterion changes resulted in noticeable increases in the diagnosis of NPD in the community.

The *DSM-IV* task force made a number of further changes to the criteria for NPD to better differentiate it from other disorders with which it showed high comorbidity (see Cain et al., 2008). Thus, because the criterion reflecting negative reactions to criticism, as written, did not adequately differentiate NPD from paranoid and borderline personality disorders, it was dropped. The lack of empathy criterion was revised to increase discrimination of NPD from the lack of remorse exhibited in antisocial personality disorder. Furthermore, the envy criterion was revised based on findings that NPD patients frequently infer that others are envious of them. The committee also added the criterion of arrogant, haughty behaviors or attitudes. The current *DSM-IV* criteria for NPD include the following characteristics:

1. grandiose sense of self-importance;
2. a preoccupation with fantasies of unlimited power, success, brilliance, beauty, or ideal love;
3. belief that he or she is "special" or unique and can only be understood by, and should associate with, other special or high status people or institutions;
4. requiring excessive admiration;
5. a sense of entitlement;
6. interpersonal exploitativeness;
7. lack of empathy;
8. envy of others or belief that others are envious of him or her; and
9. arrogant, haughty behaviors or attitudes.

FINDINGS RELATED TO *DSM-IV* CRITERIA

Although many of the changes to NPD criteria from *DSM-III* to *DSM-III-R* and *DSM-IV* were the result of increased attention to empirical findings, Cain et al. (2008) noted that many findings relating to underlying

vulnerable themes continued to be neglected, and others have stressed this idea as well (Levy, Reynoso, Wasserman, & Clarkin, 2007). Using Q-factor analysis for patients who met criteria for NPD, Russ, Shedler, Bradley and Westen (2008) identified three subtypes: grandiose/malignant, fragile, and high functioning/exhibitionistic (see also Chapter 2, this volume). Russ et al. described grandiose narcissistic patients as angry, interpersonally manipulative, and lacking empathy and remorse; their grandiosity was viewed as primary rather than defensive or compensatory. In contrast, fragile narcissistic patients demonstrate grandiosity under threat (defensive grandiosity) and experience feelings of inadequacy and anxiety indicating that they vacillate between superiority and inferiority. High functioning narcissistic patients are grandiose, competitive, attention seeking, and sexually provocative, and they tend to show adaptive functioning and use their narcissistic traits to succeed. Thus, it appears that distinct subtypes of narcissistic patients may exist even within *DSM-IV* NPD, including narcissistic patients characterized by vulnerable concerns that are not captured by the criterion set.

Other aspects of the phenomenology of narcissism not reflected in *DSM-IV* have been identified as well. Westen and Shedler (1999) surveyed a large group of experienced psychiatrists and psychologists of varying clinical orientations regarding the personality characteristics of patients with varying personality disorders, including NPD. Using factor analytic procedures to derive an empirical profile, they found that narcissistic patients as described by clinicians appear to be more controlling, more likely to get into power struggles, and more competitive than *DSM-IV* suggests. Together, these studies suggest that the revision to the NPD criterion set for *DSM-IV* may have sacrificed the true phenomenological nature of the disorder in an effort to avoid overlap with other diagnoses.

COMPARISON OF NARCISSISM IN THE DSM WITH NARCISSISM IN OTHER SYSTEMS

In addition to the *DSM* criteria, several other diagnostic models have been proposed in the literature for conceptualizing NPD. Kernberg (1975, 1984) and Akhtar and Thomson (1982) have provided the most systematic conception of NPD from a psychoanalytic standpoint, and Beck and Freeman (1990) proposed the most systematic cognitive conception. Furthermore, a number of authors have described assessing and diagnosing personality disorders from a radical behavioral framework (e.g., Koerner, Kohlenberg, & Parker, 1996; Nelson-Gray & Farmer, 1999). Other classification systems have been developed that categorize NPD in notable ways, including the *ICD-10* (World Health Organization, 1992) and more recently, the

Psychodynamic Diagnostic Manual (PDM; Psychodynamic Diagnostic Manual Task Force, 2006).

Beck and Freeman (1990) proposed that diagnosing and assessing personality disorders be based on the assumption that each personality disorder can be classified by unique cognitive distortions and maladaptive core and conditional beliefs. These cognitive contents are inferred on the basis of patients' behaviors. Beck and Freeman listed the following examples of the narcissistic individual's core beliefs: "Since I am special, I deserve special dispensations, privileges, and prerogatives"; "I am superior to others, and they should acknowledge this"; and "I'm above the rule" (pp. 50–51). Nelson-Gray, Huprich, Kissling, and Ketchum (2004) examined the relationship between specific dysfunctional thought patterns (or beliefs) and personality disorder. Although specific dysfunctional thought patterns were generally related to corresponding personality disorders, most thought patterns lacked specificity. For example, in addition to narcissistic thought pattern scores, histrionic, avoidant, dependent, paranoid and obsessive–compulsive thought pattern scores were also significantly related to NPD scores (and histrionic thought pattern was the most highly correlated scale with a NPD diagnosis).

Young (1994) developed a schema-focused approach to the treatment of personality disorders by hypothesizing that personality disorders are the result of one of 18 early maladaptive schemas. Young and Flanagan (1998) suggested that those with NPD are characterized by three core maladaptive schemas (entitlement, emotional deprivation, and defectiveness) and a number of secondary schemas (e.g., approval seeking, subjugation, mistrust, avoidance) that are clustered into separate aspects of the self (special self, vulnerable child, and self-soother), which all alternate in reaction to changes and events in the environment. Young (1994) developed a measure to assess which schemas are present or active. However, to date there has not been any research examining the validity of this model.

From a radical behavioral framework, Koerner et al. (1996) described a functional analytic assessment procedure in which, in addition to patients' reports of their behaviors toward others, the therapist's private reactions and feelings are central to diagnosis. They noted that if a therapist feels demeaned and belittled, the patient may have features of NPD. It is interesting to note that the approach advocated by these authors is very similar to traditional psychoanalytic approaches, in which clinicians are encouraged to improve their diagnostic accuracy by focusing on their own countertransference responses to patients (Kernberg, 1975).

From a psychoanalytic conception, Kernberg (1975, 1984) classified narcissism along a dimension of severity, from normal to pathological, and identified three levels of pathological narcissism: high-, middle-, and low-functioning groups. At the highest level, patients are able to achieve the

admiration necessary to gratify their grandiose needs. These patients may function successfully during their lifetime but are susceptible to breakdowns with advancing age as their grandiose desires go unfulfilled. At the middle level, patients present with a grandiose sense of self and have little interest in true intimacy. At the lowest level, patients present with comorbid borderline personality traits. These patients' sense of self is generally more diffuse and less stable; they frequently vacillate between pathological grandiosity and suicidality. In addition, Kernberg (1975, 1984) identified an NPD subtype known as malignant narcissism. Patients with this disorder are not only characterized by typical NPD symptoms but also display antisocial behaviors, tend toward paranoid features, and take pleasure in aggression and sadism toward others. They are thought to be at high risk for suicide, despite the absence of depression, because suicide for these patients is thought to represent sadistic control over others, a dismissal of a denigrated world, or a display of mastery over death. Despite the richness of Kernberg's descriptions, to date there has been no direct research on malignant narcissism.

More recently, in response to growing dissatisfaction with the DSM approach within the psychodynamic community, a task force was created by the major psychoanalytic organizations that developed a diagnostic manual integrating descriptions of internal dimensions and external manifestations of disorders (Psychodynamic Diagnostic Manual Task Force, 2006). The PDM has adopted two of the aforementioned conceptual distinctions in its approach to classifying NPD. First, the PDM explicitly states that patients with NPD should be characterized according to level of severity. Like Kernberg, the PDM describes narcissistic pathology on a continuum from neurotic to more severely disturbed personality pathology. On the neurotic end of the continuum, individuals may have strong needs for admiration but may be socially adept and successful enough to function in social and occupational environments and receive some degree of the sought admiration; deeper intimacy may be more difficult to achieve. At lower levels, the deficient capacity for intimacy may interfere significantly with social and occupational functioning, whereas the lowest level of pathology parallels Kernberg's description of malignant narcissism. Second, the PDM distinguishes between an arrogant/entitled type, which parallels the description of grandiose narcissism, and a depressed/depleted type, which parallels the description of vulnerable narcissism. Whereas the arrogant/entitled type is more closely aligned with the DSM description of NPD, including overtly haughty, entitled, and devaluing behaviors, the depressed/depleted type characterizes individuals who are quietly envious of and wounded by the success of others, with whom they nonetheless may try to ingratiate themselves.

In contrast to the clinically rich description of narcissistic pathology in the PDM, the ICD-10 (World Health Organization, 1992) does not specifically

define the characteristics of NPD. This diagnosis is not one of the eight main personality disorders, but instead is classified in the category "Other Specific Personality Disorders," and thus no specific criteria are articulated. In the ICD-10 system, to meet criteria for NPD the individual must meet none of the specifications for the main personality disorders (i.e., paranoid, schizoid, dissocial [antisocial], emotionally unstable [borderline], histrionic, anankastic [obsessive-compulsive], anxious [avoidant], and dependent). Given that NPD has been found to have problematically high overlap with other Axis II disorders, most notably antisocial, histrionic, borderline, and passive-aggressive personality disorders (see Levy et al., 2007), with comorbidity rates often exceeding 50%, the NPD diagnosis is therefore of limited use in the ICD-10 system.

PROPOSED CHANGES FOR NPD IN DSM-5: RATIONALE AND CRITIQUES

Initial proposals from the American Psychiatric Association's Personality Disorders Work Group indicated that NPD would be deleted as a personality type from DSM-5, along with four other DSM-IV disorders (Skodol, Bender, Morey, et al., 2011; Skodol, Clark, Bender, et al., 2011), because of low prevalence and insufficient research as compared with other retained disorders. Rather than represent NPD as a diagnosis in its own right, characteristics of pathological narcissism and NPD were to be captured through dimensional ratings of five personality disorder types (antisocial, avoidant, borderline, obsessive-compulsive, and schizotypal); six higher order personality trait domains (negative emotionality, introversion, antagonism, disinhibition, compulsivity, and schizotypy); levels of self and interpersonal functioning; and failures in adaptive functioning. This system was intended to provide a multidimensional profile of personality types and traits, pathology, and level of functioning. The work group argued that these proposed revisions would reduce the excessive comorbidity among personality disorders, provide official recognition that many forms of personality pathology occur on a continuum, and replace the unstable behavioral personality disorders criteria with personality traits that are more stable over time, thus providing a richer and more clinically useful portrayal of personality pathology and narcissistic functioning.

After the publication of the work group's proposal, however, several critiques emerged among the scientific community regarding both the hybrid model for assessing personality pathology in general and the exclusion of NPD as a personality type. Many found the proposed hybrid model to be cumbersome and potentially difficult for clinicians to use with its combined prototype matching and personality trait dimensional rating scales (Pilkonis,

Hallquist, Morse, & Stepp, 2011; Shedler et al., 2010). Samuel, Lynam, Widiger, and Ball (2011) noted that the trait domains for assessing narcissism were quite limited; whereas the *DSM-IV* personality disorders retained as "types" in *DSM-5* were described by nine to 11 separate trait dimensions, the disorders proposed for deletion were described by far fewer, and in the case of NPD, one of the four traits proposed was simply the name of the disorder itself (narcissism). Miller, Widiger, and Campbell (2010) argued that essential traits in conceptualizing narcissism, such as maladaptive extraversion, maladaptive agreeableness, and maladaptively low neuroticism, had been excluded. Furthermore, several theorists and researchers argued that broadening the NPD criteria to include items reflective of narcissistic vulnerability, competitiveness, and hostility would significantly reduce its overlap with other personality disorders (Cain et al., 2008; Levy et al., 2007; Ronningstam, 2009, 2010; Russ et al., 2008). Widiger (2011) contended that although *DSM-IV* NPD has a low prevalence rate and is poorly researched compared with the other disorders slated for retention, a large body of research on the broader construct of narcissism and its importance for diverse outcomes (e.g., Bushman & Baumeister, 1998; Miller, Campbell, & Pincus, 2007; Ogdorniczuk, Piper, Joyce, Steinberg, & Duggal, 2009; Pincus et al., 2009) was omitted as well as its higher prevalence in clinical practice than the current *DSM-IV* criteria capture.

Responding to these criticisms, the Personality Disorders Work Group (American Psychiatric Association, 2011b) offered a significant revision of the hybrid model for assessing personality pathology in general, as well as the re-inclusion of narcissism as a personality disorder. The proposed criteria integrate many of the aforementioned suggestions, with some notable exceptions. First, the assessment of personality disorders has been streamlined considerably; patients are now rated in two major domains of impairment in personality (i.e., self and interpersonal) functioning and pathological personality traits. In the case of NPD, impairments in self-functioning would be indicated by problems related to identity and self-direction. Whereas impairment in identity may include an inflated view of the self, unlike the *DSM-IV* the proposed model also captures vacillations in self-esteem that include a deflated view of the self, thus allowing for both narcissistic grandiosity and vulnerability (Cain et al., 2008; Levy et al., 2007; Miller et al., 2010; Ronningstam, 2009, 2010). The proposed criteria also note that "emotion regulation mirrors fluctuations in self-esteem," thus recognizing the internal regulatory function (as opposed to simply the outward appearance) of these extreme self-appraisals.

Impairment in self-functioning related to self-direction includes and integrates aspects of *DSM-IV* criteria, such as the unreasonably high expectations of oneself and others and a sense of entitlement leading to lower

expectations for oneself as compared with others. Furthermore, whereas the *DSM-IV* notes that individuals with NPD demand recognition for their accomplishments, the proposed model goes one step further in noting how the need for such approval acts as a motivation for subsequent goal choices. One area not sufficiently captured by this impairment as it is presently defined, but noted by Ronningstam (2010), is the intense aggression that can be directed toward oneself in the form of self-criticism for perceived failures, as well as the intense aggression that can be directed toward others who do not meet these high standards. Another omission in this proposed domain, implied but not explicitly identified, is the trait-level maladaptive perfectionism often associated with this deficit in self-functioning (Ronningstam, 2010).

In terms of impairments in interpersonal functioning, the deficits in empathy described in the current proposal are consistent with the *DSM-IV* criteria. However, unlike the *DSM-IV*, the proposed model omits any reference to envy (i.e., feeling envious of others, as well as assuming others are envious of oneself). Ronningstam (2010) noted that empathic failures may not just be related to self-centeredness but may also be due to the affective dysregulation and subsequent retaliatory behaviors that may occur when feelings of envy, shame, and humiliation are elicited in relational contexts.

Impairment in interpersonal functioning related to intimacy reflects the *DSM-IV* description of the exploitativeness often observed in the relationships of individuals with NPD. However, the proposed model goes one step further in implying that relationships may be used instrumentally not just for external or secondary gain but also for internal regulation. There is an emphasis on the fact that not only does self-esteem vacillate and therefore needs to be regulated (rather than self-esteem simply being too high) but that individuals with NPD also look for external regulation of self-esteem in the context of relationships.

The proposed criteria for NPD also include the pathological trait facet of antagonism, as indicated by pathological grandiosity and attention seeking. As previously noted, the proposed model's definition of grandiosity goes beyond the *DSM-IV* emphasis on overt displays of entitlement to include a more covert expression of this trait, though there is still a primary emphasis on outward displays of haughty and condescending behaviors. Pathological attention seeking reflects the *DSM-IV* criteria of need for excessive admiration. However, Ronningstam (2010) noted that individuals with NPD may also be characterized by pathological avoidance of attention by others. Although narcissistic individuals may desperately seek attention for behaviors that validate a positive self-appraisal, they may also desperately avoid attention out of fear of receiving feedback that may validate a negative self-appraisal. Attention seeking as it is currently defined may not be able to adequately assess the maladaptive extraversion trait facets of dominance,

excitement seeking, and behavioral activation and approach that are a part of narcissistic grandiosity. Extraversion-related traits have been found to mediate the relationship between narcissism and several behavioral problems such as aggression and excessive risk-taking (Miller & Campbell, 2010). Furthermore, the proposed traits might not adequately capture the trait-level maladaptive agreeableness and maladaptively low neuroticism identified by Miller and colleagues.

In addition to evaluating the domains of impairment in personality functioning and pathological personality traits, the proposed *DSM-5* criteria also include an assessment of severity that places pathology on a continuum from healthy (no impairment or mild impairment) to pathological (moderate to severe impairment). The Levels of Personality Functioning Scale (American Psychiatric Association, 2011a) evaluates the degree of impairment in both self (i.e., identity and self-direction) and interpersonal (i.e. empathy and intimacy) functioning. Such assessment is consistent with both Kernberg's model and the PDM in that it allows for the disorder to be placed on a continuum from higher functioning to more severely disturbed personality pathology. Perhaps most important, this scale focuses on internal dimensions of functioning, as opposed to the *DSM-IV* Global Assessment of Functioning (GAF) Scale (Endicott, Spitzer, Fleiss, & Cohen, 1976), which primarily focuses on external functioning. This distinction is particularly important for evaluating NPD, because individuals with NPD may be "successful" in work by achieving a high status (e.g., in business or politics) and yet have malignant features characterized by a deficit in empathic relatedness to others. Whereas such individuals could receive a high GAF score, they could be rated as having more severe impairment on the Levels of Personality Functioning Scale.

CONCLUSION

Although the concept of narcissism has a long and rich history, it was not included in the *DSM* system until 1980, with the appearance of *DSM-III*. Its inclusion followed a confluence of factors, including increased clinical interest in narcissism based on the writings of Kohut (1971, 1977) and Kernberg (1975, 1984), factor-analytic and social-personality psychology research from academia (Block, 1971; Eysenck & Eysenck, 1975; Harder, 1979; Raskin & Hall, 1979; see also Frances, 1980), and increased societal awareness as a result of trends in critical social theory (Adorno, 1967; Lasch, 1979; Marcuse, 1955; Wolfe, 1977). *DSM-III-R* and *DSM-IV* brought modifications to both the approach (from a mixed polythetic-monothetic category to an entirely polythetic one) and criterion sets (e.g., the elimination of a criterion regarding

4

NARCISSISM IN THE PSYCHODYNAMIC DIAGNOSTIC MANUAL

EVE CALIGOR

One of the strengths of the psychodynamic tradition is the emphasis it places on evaluating and treating personality pathology. Contemporary psychodynamic approaches to the diagnosis of personality disorders typically combine assessment of personality traits, or personality style, with evaluation of certain key psychological functions that underlie healthy and pathological personality functioning. This approach is described and used in the “Personality Patterns and Disorders” section of the *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006); it is summarized in this chapter.

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Understanding and Treating Pathological Narcissism, J. S. Ogronczuk (Editor)

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PSYCHODYNAMIC APPROACHES TO EVALUATING AND DIAGNOSING PERSONALITY PATHOLOGY

Clinical Illustration

Mr. B. (the patient's identity has been disguised to maintain confidentiality) is a 38-year-old married, unemployed lawyer seen in consultation with a complaint of "problems with work." Though the interview initially focused on his recent difficulty finding a job in a challenging economic environment, it emerged that Mr. B. had been fired from a series of jobs since graduating law school 10 years earlier. When employed, he quickly became bored with his work and as a result often failed to complete projects and missed deadlines. He also had a history of falsifying time sheets and frequently calling in sick. He felt that his behavior was justified—he was underpaid and as a result entitled to take extra time and money as he was able. He had most recently worked as a paralegal, a job he found demeaning, and had been fired 6 months earlier in the setting of an argument with his supervisor, whom he described as a "pompous fool." In discussing his difficulty finding work, Mr. B. repeatedly complained about "the suits" walking around out there making "wads of money" and feeling themselves to be "superior." Mr. B. described himself as alternating between feeling smarter than everyone and like a "dumb loser." He demonstrated no feeling for his wife and explained that he stayed in the marriage because of the financial support she provided. He told the consultant that even though his wife was very beautiful and he had originally seen her as the most wonderful woman he had ever met, he had lost sexual interest in her early in the marriage, and he periodically visited prostitutes. When asked to describe his wife he responded that she was "too serious and boring" and could say little more. He complained of feeling empty, bored, and restless. He wanted the consultant to tell him how to feel less dysphoric and anxious and how to have a more stable sense of himself as exceptional. At the end of an hour-long interview, the consultant found himself with only a vague and superficial sense of Mr. B. and an even more shadowy image of his wife. The consultant felt overwhelmed with the intractability of Mr. B.'s difficulties and was concerned that Mr. B. had little genuine motivation for treatment.

Mr. B. has a narcissistic personality disorder (NPD) and a borderline level of personality organization. This diagnosis can provide a great deal of information about him, including the nature and severity of his pathology, his prognosis, and his central anxieties and vulnerabilities. This diagnosis can also be used to guide treatment planning and to anticipate difficulties likely to emerge in treatment, as well as reactions a treating clinician is likely to experience in relation to Mr. B.

Personality and Personality Pathology

Personality refers to the relatively stable ways of thinking, feeling, behaving, and relating to others (described as personality traits) that characterize an individual's experience and behavior. Personality also includes the individual's moral values and ideals. In the normal personality, personality traits are not extreme and they are flexibly activated in different settings, allowing for adaptation to external demands and to internal needs. In contrast, in the setting of personality pathology, personality traits are more extreme, and they are rigid, which is to say that they are automatically and repeatedly activated, even in settings in which they are maladaptive. When rigidity of personality functioning becomes sufficiently extreme to cause clinically significant distress or failure of adaptation, the condition is called a *personality disorder*.

Descriptive and Structural Assessment

When assessing personality pathology, evaluation of personality traits enables the clinician to make a descriptive diagnosis of a particular personality disorder. The descriptive features of a personality disorder include personality traits, which can be observed by a third party (e.g., a sense of entitlement, shyness), along with characteristic, rigidly fixed internal experiences (e.g., recurrent grandiose fantasies, chronic self-doubt) that can be reported by the individual. The descriptive approach to diagnosing personality pathology is the approach taken in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). Each of the 11 DSM-IV-TR personality disorders is defined by a constellation of personality traits that tend to cluster together; the diagnosis of a particular personality disorder is made when the patient endorses a specified number of the traits that characterize that disorder. A descriptive diagnosis enables the clinician to anticipate central anxieties that organize the patient's internal experience and interpersonal behavior and that are likely to emerge in the early phases of treatment.

A psychodynamic evaluation of personality pathology couples assessment of descriptive features of personality pathology with evaluation of core psychological functions or capacities (often referred to as *structures* in the psychoanalytic literature) that organize both normal personality functioning and personality pathology. Structural assessment provides essential information about the nature of personality functioning and the severity of pathology and can be used to guide treatment planning.

The psychodynamic structural approach to classifying personality pathology was originally developed by Otto Kernberg (Kernberg & Caligor, 2005),

and the approach presented in this chapter is an elaboration of Kernberg's original formulations. Kernberg has focused in particular on the psychological functions of identity (sense of self and sense of others), defensive operations (characteristic ways of coping with external stressors and internal anxieties), and reality testing (capacity to distinguish internal from external reality) to classify personality pathology. Based on evaluation of identity formation, defenses, and reality testing, the personality disorders can be characterized on a dimension of severity, ranging from neurotic personality organization at the healthiest end of the personality disorders, through high borderline personality organization to, at the most severe end of the spectrum, low borderline personality organization.¹ The relationship between this classification of personality pathology and the *DSM-IV-TR* (American Psychiatric Association, 2000) personality disorders is represented in Figure 4.1.² The figure illustrates that each of the 11 personality disorders listed in the manual is associated with a range of severity of psychopathology.

The neurotic personality disorders are characterized by fully consolidated identity, corresponding with an integrated, realistic, complex, and stable experience of self and others. Personality rigidity, often limited to a particular area of difficulty, reflects the impact of repression-based³ defenses on psychological functioning and interferes with optimal coping and adaptation. The neurotic personality also makes use of more adaptive, mature defenses,⁴ and reality testing is intact and stable. Borderline level of personality organization (BPO) is characterized by pathology of identity formation, corresponding with superficial, extreme, black-and-white, and often unstable, caricaturelike experiences of the self and others. Personality rigidity is severe and global. In BPO, identity pathology is associated with the predominance of maladaptive, lower level, or splitting-based defenses,⁵ and reality testing can at times be compromised in the setting of stress or anxiety. The borderline group is divided into high BPO and the more severe low BPO. Moving from high BPO to low BPO, manifestations of identity pathology, the predominance of lower level defenses, and vulnerability of reality testing all become more extreme. In addition, low BPO

¹There is a distinction between the *DSM-IV-TR* borderline personality disorder and BPO. Borderline personality disorder is a specific personality disorder, diagnosed on the basis of a constellation of descriptive features. BPO is a much broader category based on structural features, as described here; it subsumes *DSM-IV-TR* borderline personality disorder, as well as all of the severe personality disorders.

²The classification of "three-levels of personality organization" is in fact dimensional rather than categorical. In other words, there is no abrupt cutoff between the neurotic and high borderline levels of personality organization or between the high and low borderline levels of personality organization; rather, they exist on a continuum.

³Repression-based defenses include reaction formation, displacement, isolation of affect, intellectualization, neurotic projection, and repression proper.

⁴Mature or "healthy" defenses include suppression, anticipation, altruism, humor, and sublimation.

⁵Lower level or splitting-based defenses include idealization, devaluation, projective identification, omnipotence, denial, and splitting proper.

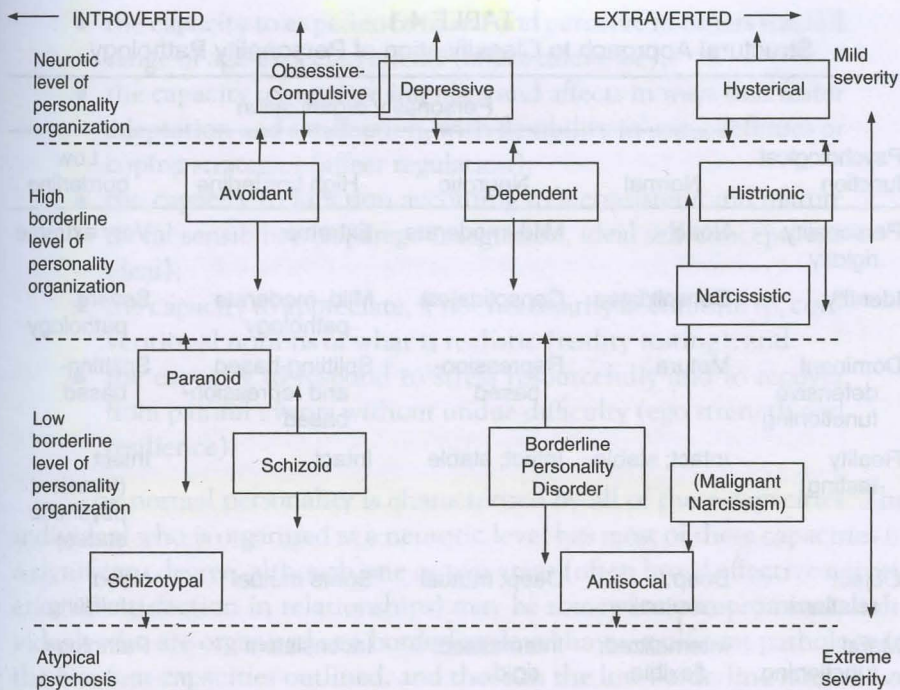


Figure 4.1. Severity ranges for each *DSM-IV-TR* personality disorder. Disorders are presented from the mildest (top of the page) to the extremely severe (bottom of the page). Vertical arrows indicate ranges of severity. *DSM-IV-TR* = *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.).

is characterized by significant pathology of moral functioning, an inability to form stable or meaningful relationships, and the dominance of aggression in affective experience (see Table 4.1).

Mr. B., introduced at the beginning of this chapter, can be seen to have a personality that is organized at a low borderline level. His sense of self is characterized by instability and a lack of depth; he defines himself in relation to others, as either superior or inferior, "the best" or "the worst." Mr. B.'s view of his wife is similarly unstable and extreme; originally "the most wonderful," she is currently someone he devalues. His experience of her is superficial and vague ("too serious and boring"), similar to his view of the people he worked with as "fools" and "suits"; even when pressed he was unable to provide a three-dimensional description of anyone in his world. Mr. B.'s defensive style relies heavily on the lower level defenses of idealization and devaluation (e.g., his wife, his boss), as well as lower level projection (his sense that the "suits" are out to humiliate him). As far as we know, Mr. B.'s reality testing is, for the most part, intact. He is severely impaired in

TABLE 4.1

Structural Approach to Classification of Personality Pathology

Psychological function	Personality organization			
	Normal	Neurotic	High borderline	Low borderline
Personality rigidity	None	Mild–moderate	Extreme	Very extreme
Identity	Consolidated	Consolidated	Mild–moderate pathology	Severe pathology
Dominant defensive functioning	Mature	Repression-based	Splitting-based and repression-based	Splitting-based
Reality testing	Intact; stable	Intact; stable	Intact	Intact (transient psychotic states)
Object relations	Deep; mutual	Deep; mutual	Some mutual	Need fulfilling
Moral functioning	Internalized; flexible	Internalized; rigid	Inconsistent	Pathology
Affects	Complex; well modulated	Complex; well modulated	Poorly integrated; poorly modulated and unstable	Crude; extremely poorly modulated and unstable

his capacity to form meaningful relations with others; he is overtly exploitative of his wife and seems to demonstrate no genuine attachment to her, while at the same time describing her as his closest relation. Pathology in moral functioning is expressed in Mr. B.'s lack of guilt and rationalizations about falsifying time sheets, as well as his financially exploiting his wife and lying to her about using prostitutes.

The authors of the "Personality Patterns and Disorders" section of the PDM (PDM Task Force, 2006) elaborated on Kernberg's formulation, identifying seven dimensions of psychological functioning that can be used to characterize severity of personality pathology and to make a structural assessment of personality functioning (the psychoanalytic term for each function described is in parentheses):

- the capacity to view the self and others in complex, stable, and accurate ways (identity);
- the capacity to maintain intimate, stable, and satisfying relationships (object relations);

- the capacity to experience in self and perceive in others the full range of age-expected affects (affect tolerance);
- the capacity to regulate impulses and affects in ways that foster adaptation and satisfaction, with flexibility in using defenses or coping strategies (affect regulation);
- the capacity to function according to a consistent and mature moral sensibility (superego integration, ideal self-concept, ego ideal);
- the capacity to appreciate, if not necessarily to conform to, conventional notions of what is realistic (reality testing); and
- the capacity to respond to stress resourcefully and to recover from painful events without undue difficulty (ego strength and resilience).

The normal personality is characterized by all of these capacities. The individual who is organized at a neurotic level has most of these capacities to a significant degree, although one or two areas (often broad affective experience or satisfaction in relationships) may be somewhat compromised. Individuals who are organized at a borderline level have significant pathology in the first four capacities outlined, and those in the low borderline range have greater pathology across Dimensions 1 through 4 in addition to pathology of moral functioning and variable reality testing.

Implications for Treatment

Structural assessment and diagnosis have implications for treatment planning and enable the clinician to anticipate problems likely to emerge in the treatment of particular groups of patients. Individuals organized at a neurotic level have an excellent prognosis in general and do well in relatively unstructured dynamic therapies. Clinicians typically find that patients who are organized at a neurotic level are easy to understand and easy to empathize with. Individuals organized at a high BPO may do poorly in unstructured treatments but have a very positive prognosis in more structured psychodynamic therapies. They may appear to be organized at a neurotic level at first glance, but they are far more likely than neurotic patients to quickly elicit strong emotional reactions in their therapists. Individuals in the low borderline range have a more guarded prognosis and typically behave in destructive and self-destructive ways in relation to a clinician. These individuals require treatments specially tailored to address their psychopathology (see, e.g., Chapters 14 and 15 of this volume) and are best treated by clinicians specially trained to manage the very powerful and often unpleasant emotional reactions that low borderline patients routinely elicit in those who treat them.

PDM APPROACH TO EVALUATING AND DIAGNOSING NPD

Within a contemporary psychodynamic frame of reference, the diagnosis of NPD includes a broad spectrum of patients with very different, often seemingly contradictory, presentations and very different clinical needs. In fact, on the dimension of severity, NPD includes the broadest range of psychopathology of all the personality disorders (Figure 4.1). There are, however, core structural and descriptive features that characterize the narcissistic personality at all levels of severity.

Structural Features of NPD: Identity, Defenses, and Reality Testing

From a structural perspective, at the core of NPD is pathology of identity formation or pathology of the self. As a result, all patients with the diagnosis of NPD are seen to be organized at a borderline level of personality organization (Kernberg & Caligor, 2005). However, NPD includes patients who fall across the entire borderline spectrum, ranging from the bottom of the low borderline level of personality organization through the healthiest range of the high borderline spectrum. The broad and inclusive approach to the diagnosis of NPD that we describe is to be distinguished from the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; DSM-IV; American Psychiatric Association, 1994) classification described in Chapter 3, this volume; the DSM classification describes a relatively homogenous and highly disturbed group falling at the more pathological end of the narcissistic spectrum.

At the healthiest end of the narcissistic spectrum, patients may, on initial presentation, appear to have normal identity consolidation and thus to fall in the neurotic range of personality organization. These individuals are typically socially appropriate, often professionally and socially successful, charming, and even charismatic. Stable relationships may be maintained, although always characterized by some degree of superficiality, an underlying quid pro quo orientation, and a lack of intimacy. In contrast, at the more pathological end of the spectrum NPD is one of the most severe personality disorders, falling in the low borderline range of personality organization. Patients in this group, sometimes referred to as suffering from *malignant narcissism*, present with an unstable and grossly distorted sense of self and of others, extremely disturbed relationships marked by frank exploitation and sadism, and severe pathology of moral functioning characterized by antisocial behavior. At the most severe end of the spectrum is NPD, comorbid with antisocial personality disorder or psychopathy.

Identity formation is evaluated by exploring the individual's experience of self and of significant others. In the narcissistic spectrum, identity pathology has a particular presentation that, to some degree, distinguishes NPD from

other personality disorders of comparable severity. For example, in contrast to borderline personality disorder, where clinicians typically see unstable, unrealistic, superficial, polarized and contradictory experiences of self as well as of others, patients with NPD have a relatively stable experience of self, and at the healthier end of the spectrum they may appear to be relatively well integrated. This apparent integration of the sense of self is in marked contrast with the view of significant others, which is characteristically vague, caricature-like, and markedly superficial. For example, a woman with NPD might provide what she views as an adequate description of her husband by saying "He is tall, a workaholic, has a bad temper, and drinks too much." When asked to describe a significant other, individuals with NPD, even those who are high functioning, are typically unable to provide a description of sufficient subtlety or depth to enable the examiner to develop a three-dimensional view of the person being described.

Although the most striking manifestation of identity pathology in NPD is the marked lack of depth in the experience of others, on careful evaluation one can identify more subtle pathology in the sense of self as well. In NPD, self-experience, even if relatively stable, is superficial; it is based on comparison with others, or on recent achievements or failures, rather than on a truly integrated, internalized sense of self. This superficiality in the sense of self often leads to feelings of being "chameleonlike" or incomplete, and it leaves the narcissistic individual poorly equipped to weather disappointments or setbacks. In NPD, as identity pathology becomes more severe, overt pathology in the sense of self as well as in the sense of others emerges; self experience is characterized by idealized and, alternatively, devalued views of the self, which are extreme, unrealistic, and often unstable.

Individuals with NPD rely on a wide spectrum of defenses, including both lower level, splitting-based, and at the healthier end of the spectrum, repression-based defenses. Across the spectrum of severity, the splitting-based defenses of idealization and devaluation are central to psychological functioning. These defenses lead to polarized, extreme, and often unstable views of others and often of the self as well. For example, a man may initially experience a woman he is dating as literally the most wonderful woman he has even known, and then several weeks or even days later, perhaps in the setting of frustration or disappointment, experience her, equally concretely, as totally uninteresting and lacking any redeeming features. In NPD, idealization and devaluation, coupled with omnipotence, denial, and rationalization, function together to protect against feelings of inferiority and inadequacy, vulnerability, envy, and shame. At the more severe end of the severity spectrum, individuals rely predominantly on these and other lower level defenses such as splitting and projective identification. In contrast, in healthier narcissistic individuals we see a defensive style characterized by a combination

of splitting-based defenses and higher level, repression-based defenses, such as reaction formation, intellectualization, isolation of affect, and repression proper.

In NPD, reality testing is intact and stable. However, there is a caveat to this statement. As narcissistic pathology becomes severe, reliance on omnipotence becomes more extreme. In this setting, the individual's experience becomes "Because I want or need or believe it to be so, it is." This kind of thinking can lead to apparent breaches in reality testing. For example, a scientist may claim that he did all of the work leading up to a particular publication, when in fact his graduate student had initiated the project and done the bulk of the work. In the setting of NPD, it can be difficult to be sure whether the scientist is lying or whether he truly believes that the work is his own, because he wants it to be.

Descriptive Features of NPD

Although there are many different presentations of NPD, there are core descriptive features shared by all individuals with narcissistic pathology: pathological self-esteem maintenance; pathology of interpersonal relations; and painful subjective states characterized by feelings of emptiness, meaninglessness, or boredom.

Pathological Self-Esteem Maintenance

Regardless of the particular presentation or severity of psychopathology, pathology of self-esteem maintenance is the cardinal descriptive feature of NPD. All individuals with NPD have profound problems with self-esteem and spend great amounts of time evaluating their status relative to others. To feel good about themselves, they need to feel special and superior, and because they lack an internalized sense of being "good enough," they require constant confirmation of their superiority in the form of admiration, elevated status, wealth, power, beauty, and success. Similarly, individuals with NPD generally affiliate themselves only with those they perceive to be of higher status, as a way to feel more important or special by association; devaluing others is another way to feel superior. When the narcissistic individual succeeds in extracting confirmation of being special and superior, he or she feels an internal elation, often behaves in a grandiose manner, and treats others (perceived to be of lower status) with contempt. When the environment fails to fuel the individual's grandiosity, narcissistic individuals typically feel depressed, shamed, painfully envious of, and devaluing toward those they perceive as obtaining the supplies that they lack. Because their sense of self and self-worth is so fragile and dependent on external supplies, individuals with NPD are excessively sensitive to criticism or slights.

Arrogant/Entitled Subtype. Many individuals with NPD have a predominantly grandiose and arrogant style, labeled Arrogant/Entitled (PDM Task Force, 2006); this subtype includes individuals who have been described in the literature as “oblivious” (Gabbard, 1989), “thick-skinned” (Rosenfeld, 1987), or “overt” (Akhtar, 1989) narcissists. People in this group are overtly grandiose, feel entitled to special treatment, and are either perplexed or enraged (or both) when they do not receive it. They devalue most other people and typically strike observers as vain, manipulative, and self-involved; alternatively, they may seem charismatic and commanding. Other individuals in this group are more overtly unstable and oscillate, depending on circumstances, between two contradictory and discrete self states: feeling grandiose and expansive on the one hand and depleted, depressed, and shamed on the other.

Depressed/Depleted Subtype. A group of individuals with NPD fall into the *Depressed/Depleted* (PDM Task Force, 2006) subtype; they do not present with overt grandiosity but rather are overly diffident and often painfully shy. (This subtype is not included in any version of the DSM.) Individuals in this group, often misdiagnosed as depressive, masochistic, or avoidant, are described in the literature as “thin-skinned” (Rosenfeld 1987), “hypervigilant” (Gabbard, 1989), or “covert” (Cooper & Ronningstam, 1992) narcissists. People in this group experience themselves as deficient or damaged and want to know how to be “normal” or to have what more fortunate people have. These individuals are highly self-critical, easily slighted or wounded, and suffer from chronic feelings of envy in relation to others, whom they regard as superior. However, underneath their conscious inferiority and preoccupations with others, they harbor grandiose fantasies and views of themselves, feel entitled to special treatment, and are highly preoccupied with themselves.

Pathology of Interpersonal Relations

Pathology of interpersonal relations is another descriptive anchor shared by all individuals with NPD. At the healthiest end of the narcissistic spectrum, these features may be both subtle and covert; as pathology becomes more severe, views of relationships and interpersonal functioning become increasingly pathological. However, across the spectrum of severity, individuals with NPD lack a capacity for genuine intimacy and mutual dependency, and they have limited ability to value the needs of others independent of their own needs. Relationships are superficial and are seen as a means to an end, either to advance a particular purpose or to enhance self-esteem. The interpersonal relations of the individual with NPD are characterized by a lack of genuine interest in the other person as an individual, beyond the status, power, narcissistic supplies, and need fulfillment associated with the relationship. In all relationships there is a consciously considered sense of

“what I get out of it” and “what I give,” with attention to “who gets more.” More disturbed individuals are overtly exploitative or parasitic, openly using others to meet their own needs with no sense of wrongdoing and then discarding them when they are no longer useful. Individuals at the healthier end of the narcissistic spectrum may be vulnerable to feeling exploited themselves or may be quietly detached while remaining attentive to what each person brings to the relationship.

“Lack of empathy” is often included in criteria for NPD, and it is important to define exactly what is meant by *empathy*; empathy involves both the ability to perceive the inner psychological states of others as well as the capacity to identify with and feel the feelings and needs of other people. Some oblivious narcissistic individuals have deficits in both areas; however, other narcissistic individuals may be highly astute when it comes to perceiving the internal experience of others. In particular, they may be highly attuned to the vulnerabilities of others but lack the concern or genuine interest that might accompany awareness of another person’s inner state and instead use their understanding of others in a self-serving fashion.

Painful Subjective States

Individuals with NPD are vulnerable to painful subjective states characterized by feelings of emptiness, meaninglessness, and boredom. When grandiosity is fueled, these feelings can be temporarily avoided; the recurrent need for external confirmation described above can function to ward off negative affect states. However, when external supplies are not provided, the individual may be flooded with painful feelings of emptiness and meaninglessness. At the healthier end of the spectrum, individuals with NPD may throw themselves into work; when they work on something that they view as special and important and meet with success, feelings of elation may replace emptiness and boredom. However, the emotional benefits of success are short-lived, and as soon as the pace slows, feelings of restlessness and boredom quickly return. Some individuals with NPD use the promise of a new relationship in the same way, turning to the thrill of pursuit and promise of conquest or of connection with an idealized other to feel (temporarily) engaged and alive. Still others turn to substances to avoid intolerable internal states. The internal states characteristic of NPD are linked to a characteristic inability to make emotional investments in depth. The individual with NPD typically displays a lack of deeper commitments to specific values or ideals, which often come and go, along with a poorly developed capacity to make lasting investments in a profession, relationship, hobby, or intellectual interest, beyond the wish to obtain narcissistic supplies. A scholar may work hard to attain public recognition but become bored with his subject matter; an administrator may seek power and money but have no interest in actually making a system work;

an entrepreneur may obsessively build a business but abruptly lose interest when it no longer promises to be a dramatic success. The lack of genuine pleasure or capacity for in-depth and sustained emotional, intellectual, or spiritual investments, and the sense of meaninglessness or emptiness that commonly accompanies this deficit, can be painful to witness.

Associated Features

Pathology of moral functioning is often, though not universally, associated with NPD. As a result, careful assessment for a history of illegal or unethical behavior should always be part of the clinical evaluation of the patient with NPD. In individuals with NPD who are organized at a low borderline level, severe pathology of moral functioning is coupled with ego-syntonic exploitation of others. Unethical and illegal behaviors are typically executed in the setting of feelings of entitlement and a lack of a sense of wrongdoing. These individuals may become involved in violent crime as well as nonviolent criminal behavior. In those with NPD organized at a high borderline level, moral pathology is often covert (e.g., a visibly ethical individual who proves to be involved in some kind of dishonest activity, much to everyone's surprise). Common presentations include everything from plagiarism, to infidelity, to white collar crime. Highly successful people who violate professional ethics are often narcissistic; examples include financiers who become involved in "insider trading" or medical researchers whose financial interests lead them to falsify scientific work. The typical pattern involves rationalizing behavior the individual with NPD understands to be unethical or illegal. Somatization and hypochondria are also commonly associated with NPD, as is substance abuse. These individuals move away from threatening or painful aspects of emotional experience and instead become preoccupied with physical complaints or fears of illness, or turn to psychoactive substances, to mitigate painful internal states.

Assessment

To make a diagnosis of NPD, one must establish (a) that the patient has a personality disorder, (b) that the patient meets the structural criteria for borderline level of personality organization in general and NPD in particular, and (c) that the patient endorses the core descriptive features of NPD.⁶

⁶The Structured Interview of Personality Organization (STIPO; Clarkin, Caligor, Stern, & Kernberg, 2004) is a semi-structured interview that evaluates personality organization. Though developed as a research tool, the STIPO provides examples of specific questions that can be used in a clinical setting to evaluate identity formation, defensive operations, quality of relationships, and moral functioning. The STIPO can be found at <http://psinstitute.org/pdf/Structured.Interview-of-Personality-Organization.pdf>

To diagnose a personality disorder, it is necessary to demonstrate that personality pathology is of sufficient severity to cause either impairment of functioning or significant distress. In the course of evaluation, we focus in particular on how the individual functions interpersonally, at work, and in his or her leisure time. Evaluation of relationships includes exploring the quality of hierarchical and peer relationships as well as intimate and romantic bonds. How stable, conflict-ridden, or stormy are these relationships? Are they meaningful to the patient, and have they been sustained across time? Are they a source of pleasure and satisfaction or of frustration and disappointment? Evaluation of functioning at work or school includes assessment of how well the individual is performing given his or her abilities and training, whether there have been recurrent areas of difficulty, and the degree to which he or she enjoys and obtains satisfaction from work. Evaluation of leisure activities, including hobbies, interests, and the capacity to enjoy recreational pursuits, rounds out the evaluator's picture of the patient's personality functioning. A comprehensive assessment of personality functioning involves asking the patient to illustrate with specific examples his or her responses to the evaluator's questions, with the goal of developing a clear and consistent picture of how the patient functions in each of these domains.

After it is established that a patient has a personality disorder, the next step is to evaluate personality organization. Structural criteria for the diagnosis of NPD include pathology of identity formation and the presence of prominent splitting-based defenses, in particular, idealization and devaluation. To evaluate identity formation, it is useful to begin by asking patients to identify two people who are important to them. The next step is to ask the patient to describe each of these people in sufficient detail to enable the evaluator to get a clear and three-dimensional picture of who the significant other is as an individual. If the patient provides a string of adjectives, it can be helpful to point this out and ask for greater detail. If the patient provides descriptors of only a single valence, either all positive or all negative, this too can be pointed out. Throughout this process the evaluator is assessing whether the patient has a view of significant others that is complex and well differentiated, involving subtlety and shades of gray, consistent with fully integrated identity and neurotic level of personality organization, or whether descriptions of significant others are two-dimensional, superficial or vague, black-and-white and lacking subtlety, consistent with identity pathology and a borderline level of personality organization. This line of inquiry can be followed by asking the patient to paint a picture of himself or herself in a similar fashion. Most people find it more difficult to describe themselves than to describe a significant other, but individuals with normally consolidated identity are able with effort to provide a complex, multifaceted, and realistic

picture of themselves, whereas those with identity pathology are typically unable to do so.

To assess the role of splitting-based defenses in a patient's defensive organization, clinicians focus primarily on the impact that these defenses have on subjective experience. To evaluate the role of splitting-based defenses overall, it is often useful to ask patients whether they tend to see things in black-and-white terms, whether their experience of others (or of themselves) can seem discontinuous or can shift suddenly or dramatically, whether they find it difficult to accurately infer the internal experience of others, and whether they tend to ignore or deny important realities in their lives that are painful or frightening. To evaluate more specifically the impact of idealization and devaluation on psychological experience, one can ask patients whether they have noticed that they can think highly of someone and then suddenly lose interest or think poorly of them, whether they find that they can attach great value to something one day and quickly lose interest, and whether they tend to admire people or things from a distance but find they appear very differently up close.

If a patient proves to have evidence of identity pathology characterized by a vague or superficial view of significant others in conjunction with prominent splitting-based defenses, in particular, idealization and devaluation, it is time to turn to evaluation of the descriptive features of NPD. To diagnose NPD at the healthier end of the spectrum, clinicians focus in particular on the assessment of the quality of the patient's relationships. In this process, it is helpful to ask patients whether they tend to see relationships in terms of what each person is getting out of the relationship and who is getting more, whether they have ever formed a relationship with someone because the person has wealth or status or might be useful to the patient, and whether they have cut people off abruptly because the other person disappointed them or did not give them what they wanted. With patients at the more severe end of the borderline spectrum, we also evaluate how overtly exploitative and/or sadistic they are in their relationships and their attitude toward these behaviors. When evaluating narcissistic pathology, we also explore the quality and stability of self-esteem maintenance, for example by asking patients whether they tend to spend a lot of time comparing themselves with others, seeing themselves as more successful or attractive or fortunate, or perhaps as less so. To make the diagnosis of NPD, it is also useful to inquire about feelings of emptiness or boredom, especially in the setting of quiet or unstructured time. Moral functioning should always be evaluated when NPD is in the differential diagnosis. One can begin by asking patients if there are times when they have deliberately deceived others, for example, twisted the facts to make themselves look more successful or attractive to someone else or to get something they want. This line of inquiry can be followed by questions

about specific moral transgressions, including a history of lying, infidelity, tax evasion, plagiarism, questionable business practices, and overt problems with the law.

Countertransference

Individuals with NPD typically elicit strong emotional reactions from clinicians. Devaluing and overtly grandiose patients typically generate feelings of hostility, whereas healthier and more successful narcissistic patients may induce feelings of inadequacy or envy. In contrast, the patient with NPD who relies heavily on idealization can leave a clinician feeling special and admired, at least at initial contact. Thin-skinned narcissistic individuals may present as painfully fragile, leading the clinician to bend over backwards not to injure them. Regardless of their initial reactions, over time, most clinicians find themselves feeling bored by the patient with NPD. The narcissistic individual's self-preoccupation and lack of interest in anything the clinician might say or have to offer tend to generate feelings of disinterest, detachment, and demoralization at best, and hostility and contempt for the patient at worst. Clinicians can, to some degree, contain such negative feelings toward the patient with NPD by remaining mindful of the feelings of inadequacy, vulnerability, and paranoia that underlie the narcissistic individual's grandiosity and self-preoccupation.

CONCLUSION

NPD has many presentations and can be associated with pathology across a broad spectrum of severity. The clinician's capacity to identify and to comprehensively evaluate the individual with NPD rests on an understanding of the core structural and descriptive features of the disorder reviewed in this chapter. Comprehensive assessment of structural and descriptive features of narcissistic personality pathology is crucial for appropriate treatment planning.

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ing realistic limits, they may continue to pursue vain attempts toward perfection. The narcissistic person may have high ambitions but neglect to think through a specific plan in order to accomplish any of these goals. Instead, there is a fantasylike demand that, with scant effort, one suddenly ascends to the target. The result is a feeling of entitlement and an expectation of always getting the best, being first, and avoiding pain.

Any perceived talents are grasped onto and expanded upon to advance the excessive estimation of self. Tribute from others is constantly expected, yet the narcissistic person may also markedly underestimate peers. Sometimes the ruthless thrust toward self-enhancement is concealed by pseudohumility and suavity (the essential coolness of a pseudowarmth).

But the lack of concern for others is usually eventually recognized. In due course, the other person learns that he or she is being used or exploited or is disliked. As the attachment is spoiled, the narcissistic person has to befriend a new acquaintance in an attempt to gratify his or her narcissistic needs. Alternatively, he or she may bribe or blackmail the other to stay committed. In that case, it is common for the other to feel bored and restless, as the affection or loyalty is only feigned.

Given such an impoverishment of interpersonal relationships, lack of creative success, or absence of compensatory thrill-seeking or pleasure, the narcissistic person cannot maintain grandiosity. Instead, he or she is increasingly vulnerable to shame, panic, helplessness, or depression as life progresses without genuine support from admiring others. With a loss of cohesiveness in the self-concept because of lack of admiration and empathy from others, such persons may develop hypochondriasis, depersonalization, or self-destructiveness. Feelings of envy, rage, paranoia, and outrageous demands on others often develop when a narcissistic individual is subjected to the stress of degradation, including the inevitable stress of aging and declining physical appearance and function.

Talented, wealthy, or exceptionally good-looking persons driven by narcissistic personality traits often display such charisma that they can continue to take on new relationships as old relationships fracture and perish. Social climbing is often a common feature, but the narcissistic person may also cling to acquaintances that can be relied on to provide a positive reflection. When the narcissistic person feels truly powerful, he or she may discard or depreciate persons who are no longer of use in bolstering his or her self-image.

In the less talented narcissistic individual, an idealized other may be selected as a self-proxy. The weaker narcissist clings to the idealized other in order to obtain positive reflection and avoid shame. (Kohut, 1972) described interpersonal patterns in terms of mirror, idealizing, and twinship patterns of transference.

NB!

STATES OF MIND AND STATE CYCLES

A few notable states of mind are prominent in the prototypical narcissistic personality, including the state of self-righteous rage (Horowitz, 1981; Kohut, 1972). Entry into a state of self-righteous rage may be fairly explosive and sudden, as a person rapidly switches from a composed state into suddenly becoming hostile toward others. The trigger to this explosion is often the interpretation of an interpersonal encounter as involving some kind of insult.

Others often see this state of self-righteous rage as an exaggerated response because of the level of violence that it contains. Whether manifested physically or verbally, the aggressive response exceeds the usual social standards of acceptable behavior. Despite the socially unacceptable nature of the reaction, the individual feels justified in disparaging or even harming the other while in the self-righteous rage state.

This kind of towering rage can be considered narcissistic because of two important features. One is the inflated grandiosity assumed during the state. This kind of grandiosity aims to defend against an inferior, bad, or damaged self-concept. The second narcissistic feature in such rages is that others are assigned subhuman status. This is why the state is sometimes called *blind hatred*. The person flying into such rages does not recognize that other persons have a right to exist or that they have ever been good or kind to the self. There is a readiness to injure others on the grounds that they are destructive monsters who have no right to survive. This describes an extreme form, but many of these features can be recognized in more moderate representations of self-righteous rage states.

Another shading of anger may be found in the state of *chronic embitterment*. In this state, the person carries a chip on his or her shoulder and dares other people to knock it off. There may be blustery-outgoing or sullen-withdrawing forms of chronic embitterment. In comparison with indignant rage states, the hostility is subdued. Its source is an internal dialogue in which the self is being unfairly abused by others or by fate.

Whereas self-righteous rage and chronic embitterment may be fairly evident to observers and perhaps even to the individual who experiences them, there is a more confusing state that also contains angry emotions. This is a *mixed state* in which anger is intermingled with shame and anxiety. The person is unclear about which negative emotions he or she is feeling and their cause. Shame develops in response to exposing aspects of the self, including the irrational acts of anger, whereas fear can arise in response to losing control over one's anger or over further degradations to the self, which in turn can lead to further shame.

The fear present in the mixed state may become clearer as it is heightened and purified to the point of panic in what might be called a *chaotic*

state. It is during these states that fear of flying apart, losing bodily integrity, or fragmenting one's identity may become especially prominent. There can be a progression from hypochondriasis, to identity diffusion sensations, to a panicky dread of immediate death.

At the opposite end of the spectrum of psychic arousal is an unexcited state of numb, apathetic dullness. The self is enfeebled and without hope of restoration. The person entering a *leaden apathetic state* has, in a way, decided to hibernate. Of interest, this state of mind also occurs prominently during some denial phases of mourning, in which the loss of a relationship has undermined self-security, contributing to inhibition of grief in order to avoid the perceived intolerable quality of such emotional pain.

A *state cycle* may be an aspect of a repetitive, maladaptive pattern of relating. The harm of being rejected may lead to embittered states; when someone can be blamed the state may shift to indignant rage, and when that seems inappropriate, the mixed state may occur.

The range of states that exemplify different types of angry colorations (self-righteous rage, mixed state, and chronic embitterment) can be matched with an analogous series of positive states of mind. In forming the positive states, the self-concept has been bolstered, perhaps by fantasy, illusions of entitlement, restoration of self-objects, or personal accomplishment. A state of exhilaration, characterized by grand ebullience and charm, is the opposite polarity of the negative state of self-righteous rage. The negative affective mixed state of shame, rage, and fear may be related to a positive but mixed state in which there is some fear of failure together with exhilaration at potential success. There may be excitement as a result of self-elevation through sexual or creative prowess, mixed with fear that the self-enhancing actions will not meet expectations. Thus, there may be a quality of anxious impatience that mars an otherwise exciting experience. The chronic embitterment state would be analogous to a chronic hankering for attention state, a semi-positive state of being ever tuned toward social sources of praise.

Themes of success, failure, and blame are often highly emotional. The idea of public humiliation is a frequent, recurrent theme for narcissistic individuals. The person may persist in overvaluing the self in order to reduce the threat. The person may lie in an attempt to avoid acknowledging the painful reality and then further exacerbate the situation in which the exposure of lying may induce shame. Although the "ground rules" of psychotherapy emphasize honesty, this process occurs in the treatment room as well.

Because some memories are wounding to the self, they may be compartmentalized. Dissociation may occur, so that there is a fragmented sense of continuity of self over time. This can lead to a vicious cycle, as this kind of fragmentation reduces coherence in overall self-organization (Stolorow & Lachman, 1980). In other words, inferior views of self are held too far

apart from superior views of self, and more importantly, from realistically competent views of self (Rothstein, 1984; Wurmser, 1981). The person cannot mitigate a specific personal shortcoming through recalling more positive memories, because of the dissociation of experiences.

The low tolerance for certain affects, especially shame, is worth noting again. Having experienced humiliation or embarrassment, the narcissistic person may take an unusually long time to restore positive self-regard. When activated, his or her feelings of shame may have a slow rate of dissolution. Paradoxically, the person then is very demanding of a return to a more hedonic state and feels entitled to it at all costs.

In terms of normal anger, expressing hostility has an interpersonal purpose, which is to get the other person to come through or to back off. The right degree of hostility is used to accomplish this aim. In a person conflicted about anger themes, there is usually an avoidance of expressing such emotions. The anticipated consequences are that the other person will be strong and retaliatory or weak and harmed by the hostility. The self will then have to experience fear of retaliation, shame over being judged by others as being too harmful; or guilt that the other person has been hurt. In the narcissistic person, anger is not well-targeted or even clearly localized in the self. There is rage "in the air," and any object may become the target.

The rage in the narcissistic individual arises in part from the potential sense of damage to or enfeeblement of the self. The aim is destruction of the other in a more total form rather than a limited goal. As such, there is more danger in the anger because there is no plan for what may happen, or what, if any, self-governance might control the degree of expressed anger.

Similarly, in terms of shame, a person without narcissistic features prefers to defer and hide from the social criticism resulting from a shameful action or failure to act. For idiosyncratic and irrational reasons, the narcissistic person sees acceptable acts as if they were shameful. The self as constituted is shameful not only because of a specific act or failure to act; the indefinite unstructured threat of social disgrace makes this affect harder to tolerate because it exists in a sense of identity. Defenses such as reversal to anger become imperative and more pathologic in implementation.

SCHEMATA OF SELF AND OTHERS

NB! Some patients with pathological narcissism initially present with symptoms of anxiety and depression, but it later becomes apparent that they are experiencing major problems either with the self-righteous rage state, the ensuing mixed shame/rage/fear state, or with extreme efforts to ward off both states. I focus in this section on a three-party role-relationship model

6

THE PATHOLOGICAL NARCISSISM INVENTORY

AARON L. PINCUS

Despite its longevity and importance as a psychological construct, narcissism and the associated narcissistic personality disorder (NPD) have been inconsistently defined and measured across disciplines (Cain, Pincus, & Ansell, 2008; Miller & Campbell, 2008). Several recent reviews have highlighted the issues associated with integrating the empirical and clinical literature on narcissistic pathology (e.g., Levy, Reynoso, Wasserman, & Clarkin, 2007; Pincus & Lukowitsky, 2010; Ronningstam, 2005a, 2005b). Divergences in phenotypic and taxonomic models of pathological narcissism, especially inconsistencies between a century of clinical conceptualizations and NPD criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), have led to major construct definition and criterion problems that weaken the cumulative research base and obfuscate the accurate assessment of narcissistic pathology (Pincus, 2011; Pincus & Lukowitsky, 2010). With each successive edition of the manual, criteria for NPD have become increasingly narrow in scope;

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currently they capture predominantly grandiose themes of the disorder (Cain et al., 2008) while eliminating many of the clinically meaningful characteristics associated with impaired self and emotion regulation (e.g., shameful reactivity or humiliation in response to narcissistic injury, alternating states of idealization and devaluation). These are now described in the "Associated Features and Disorders" section where clinicians are also cautioned that patients may not outwardly exhibit such vulnerable characteristics.

However, if one moves beyond the manual's definition of NPD, reviews of the clinical, psychiatric, and social and personality psychology literature clearly paint a broader portrait of pathological narcissism encompassing two phenotypic themes of dysfunction, narcissistic grandiosity and narcissistic vulnerability (Cain et al., 2008; Dickinson & Pincus, 2003; Miller, Hoffman, et al., 2011; Pincus & Lukowitsky, 2010; Pincus & Roche, 2011). The lack of sufficient vulnerable NPD criteria in the *DSM-IV* (American Psychiatric Association, 1994) is now a common criticism (Gabbard, 2009; Miller, Widiger, & Campbell, 2010; Ronningstam, 2009). The overly narrow construct definition of pathological narcissism found in *DSM-IV-TR* NPD limits its clinical validity and utility because therapists and diagnosticians may be more likely to see narcissistic patients when they are in a vulnerable self-state (Kealy & Rasmussen, 2012; Pincus et al., 2009). Thus, a clinician relying solely on *DSM-IV* NPD diagnostic criteria may not recognize pathological narcissism in a presenting patient. The Pathological Narcissism Inventory (PNI; Pincus et al., 2009) was recently developed with these concerns in mind. It is a multidimensional measure of pathological narcissism that assesses both overt and covert expressions of narcissistic grandiosity and narcissistic vulnerability.

DEFINITION AND PHENOTYPIC DESCRIPTION OF PATHOLOGICAL NARCISSISM UNDERLYING THE PNI

I begin with a contemporary definition of narcissism that provides the foundation for understanding its diverse phenomenology and facilitates integration and synthesis across disciplines. I propose that *narcissism* be defined as one's capacity to maintain a relatively positive self-image through a variety of self-regulation, affect-regulation, and interpersonal processes and that it underlies individuals' needs for validation and admiration, as well as the motivation to overtly and covertly seek out self-enhancement experiences from the social environment (Pincus et al., 2009; Pincus & Roche, 2011). In basing the definition of narcissism on the individual's needs, motives, and regulatory capacities, I explicitly distinguish between what narcissism is (i.e., underlying psychological structures and processes) and how it is expressed in thought, feeling, and behavior. It is important to recognize the difference

between a definition of psychopathology and the description of individual differences in its phenomenological expression (Pincus, Lukowitsky, & Wright, 2010; Pincus & Wright, 2010), and it is the latter of the two that is typically assessed by self-report scales, diagnostic interview questions, and DSM personality disorder criteria (Pincus, 2005a, 2005b, 2011; Widiger, 1991).

I believe the fundamental dysfunction associated with pathological narcissism is related to intense needs for validation and admiration that energize the person to seek out self-enhancement experiences. Such needs and motives are normal aspects of personality, but they become pathological when they are extreme and coupled with impaired regulatory capacities. It is normal for individuals to strive to see themselves in a positive light and to seek experiences of self-enhancement (e.g., Hepper, Gramzow, & Sedikides, 2010), such as successful achievements and competitive victories (Conroy, Elliot, & Thrash, 2009). Most individuals can manage these needs effectively, seek out their gratification in acceptable ways and contexts, and regulate self-esteem, negative emotion, and interpersonal behavior when disappointments are experienced. In contrast, pathological narcissism involves impairment in the ability to manage and satisfy needs for validation and admiration, such that self-enhancement becomes an overriding goal in nearly all situations and may be sought in maladaptive ways and in inappropriate contexts. This heightens sensitivity to the daily ups and downs of life and relationships (McCullough, Emmons, Kilpatrick, & Mooney, 2003; Zeigler-Hill, Myers, & Clark, 2010) and impairs regulation of self-esteem, emotion, and behavior. This definition of pathological narcissism, unlike NPD, encompasses narcissistic grandiosity and narcissistic vulnerability.

Narcissistic Grandiosity and Narcissistic Vulnerability

To the layperson, the construct of narcissism is most often associated with arrogant, conceited, and domineering attitudes and behaviors (Buss & Chiodo, 1991), which are captured by the term *narcissistic grandiosity*. This accurately identifies some common expressions of maladaptive self-enhancement associated with pathological narcissism. However, the definition of narcissism underlying the PNI combines maladaptive self-enhancement with regulatory impairments leading to self, emotional, and behavioral dysregulation in response to ego threats or self-enhancement failures. This *narcissistic vulnerability* is reflected in experiences of anger, envy, aggression, helplessness, emptiness, low self-esteem, shame, social avoidance, and even suicidality (Akhtar, 2003; Dickinson & Pincus, 2003; Kohut & Wolf, 1978; Pincus et al., 2009; Ronningstam, 2005a). A comprehensive hierarchical model of pathological narcissism is presented in Figure 6.1. Evidence for the two phenotypic themes of narcissistic grandiosity and narcissistic vulnerability come from clinical theory, psychiatric diagnosis, and social and personality

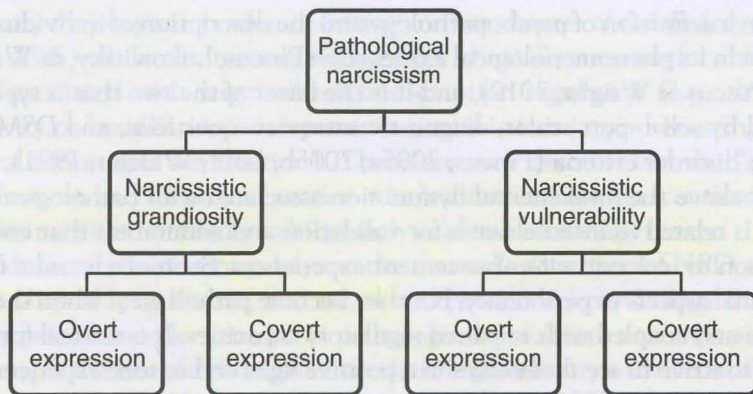


Figure 6.1. The hierarchical structure of pathological narcissism. From "Pathological Narcissism and Narcissistic Personality Disorder," by A. L. Pincus and M. R. Lukowitsky, 2010, *Annual Review of Clinical Psychology*, 6, p. 431. Copyright 2010 by Annual Reviews. Reprinted with permission.

psychology (Cain et al., 2008; Pincus & Roche, 2011); and in recent years, recognition of both grandiose and vulnerable themes of narcissistic dysfunction has increasingly become the norm (e.g., Horowitz, 2009; Kernberg, 2009; Ronningstam, 2009; Russ, Shedler, Bradley, & Westen, 2008). Narcissistic grandiosity involves intensely felt needs for validation and admiration, giving rise to urgent motives to seek out self-enhancement experiences. When this dominates the personality, the individual is concomitantly vulnerable to increased sensitivity to ego threat and subsequent self, emotion, and behavioral dysregulation (i.e. narcissistic vulnerability).

Overt and Covert Narcissism

The distinctions among overt and covert expressions of pathological narcissism are found in both clinical (e.g. Revik, 2001) and social and personality (e.g., Otway & Vignoles, 2006) psychology. Unfortunately, overt expressions of narcissism are often incorrectly associated exclusively with grandiosity and covert expressions of narcissism exclusively with vulnerability. These linkages are inaccurate, as is the view that overt and covert narcissism are distinct types or phenotypes. DSM NPD criteria, items on various self-reports, interviews, and rating instruments assessing pathological narcissism, and most certainly clinical conceptualizations of all forms of personality pathology include a mix of overt elements (behaviors, expressed attitudes and emotions) and covert experiences (cognitions, private feelings, motives, needs; e.g., McGlashan et al., 2005). In Figure 6.1, the distinction between overt and covert expres-

sions of narcissism is secondary to phenotypic variation in grandiosity and vulnerability, and there is no empirical evidence that distinct overt and covert types of narcissism exist (Pincus & Lukowitsky, 2010).

Clinical Examples

Clinical experience with narcissistic patients indicates they virtually always exhibit both covert and overt grandiosity and covert and overt vulnerability. An example of overt grandiosity involved a narcissistic patient who routinely threatened people who parked in his apartment's assigned parking space and even called his therapist to report that he planned to buy a gun and shoot the next person he found parked there. It is important to note that the patient did not own a car and did not drive. In contrast, narcissistic grandiosity can also be expressed covertly as reflected in criteria such as grandiose fantasies. A notable clinical example of covert grandiosity involved a narcissistic patient who, at midlife, was unemployed, socially isolated, and lived in his parents' basement. The patient spent most of his days fantasizing about being the loved and admired head of his own philanthropic organization while concurrently lacking any motivation or effort to address his current social, occupational, and psychological deficits. Narcissistic vulnerability can also be expressed overtly and covertly. Overt vulnerability includes angry dysregulation and suicidal reactions to narcissistic injury. One narcissistic patient became so distraught after hearing that his trust fund had been exhausted that he made a strategic suicide attempt (overdose) timed such that his mother would find him unconscious when she arrived for their weekly shopping trip. Finally, covert vulnerability includes shame, social withdrawal, and devaluation of the self in reaction to unmet idealized expectations. For example, one narcissistic patient who did not make a positive impression and elicit admiration from new neighbors became depressed and ashamed, punishing himself by not eating for days. These instances are drawn from different psychotherapies. Over the course of treatment, each of these patients exhibited instances of grandiosity and vulnerability expressed both overtly and covertly.

THE PNI

Most existing instruments assessing pathological narcissism are based on DSM NPD criteria and are thus limited to assessment of narcissistic grandiosity. The scope of most narcissism scales, from omnibus instruments assessing pathological traits such as the Schedule for Nonadaptive and Adaptive Personality (Simms & Clark, 2006) and the Dimensional Assessment of Personality Pathology (Livesley, 2006), to measures of normal narcissistic

traits such as the Narcissistic Personality Inventory (Raskin & Hall, 1981), are similarly limited. The Hypersensitive Narcissism Scale (Hendin & Cheek, 1997) does appear to assess narcissistic vulnerability, but it provides only a single global score. The PNI was constructed to assess self- and informant-reported individual differences in overt and covert expression of narcissistic grandiosity and narcissistic vulnerability that have been identified across disciplines (Pincus et al., 2009).¹ This fills a niche in clinical assessment as the only multidimensional inventory that measures seven clinically meaningful facets of pathological narcissism and generates scores for both grandiosity and vulnerability.

Initial Construction

A test construction team that included clinical faculty and graduate students, psychotherapists, and psychology undergraduates examined the theoretical and empirical literature on pathological narcissism to understand how it has been conceptualized and operationalized across disciplines, generating a comprehensive review (Cain et al., 2008). Additionally, psychotherapists working with patients who exhibit narcissistic personality pathology gave case presentations and reviewed tapes of sessions that characterized core aspects of pathological narcissism. This comprehensive review of the literature and the discussion of clinical cases culminated in the identification of seven target dimensions encompassing grandiose and vulnerable aspects of pathological narcissism. The hypothesized dimensions of narcissistic vulnerability were Contingent Self-Esteem, Entitlement Rage, Devaluing of Others and Needs for Others, and Narcissistic Social Avoidance. The hypothesized dimensions of narcissistic grandiosity were Exploitativeness, Grandiose Fantasies, and Self-Sacrificing Self-Enhancement. The test construction team generated an initial pool of 131 items tapping these seven factors. Several iterative empirical processes, including factor analyses on a sample of 796 young adults, reduced the item pool to seven factors, assessed by 52 items, which corresponded well to a priori expectations. This seven-factor structure was then validated using confirmatory factor analysis in a large independent sample of 2,801 young adults (Pincus et al., 2009).

The PNI Scales and Higher Order Factors

The PNI has 52 items tapping seven scales that reliably (α s typically range from .80 to .93) assess facets of narcissistic grandiosity and narcissistic vulnerability. Scales assessing grandiosity include Exploitativeness (EXP,

¹Requests for a PNI assessment packet can be sent to the author at alp6@psu.edu.

invariance was achieved at all levels (i.e. configural, factorial of first and second-order, disturbances, second-order variances and covariance, and intercept). Thus, the PNI can be confidently used to assess pathological narcissism in both men and women.

Scoring the PNI in Practice

Because of the variability in scale length, mean item endorsement scores are used instead of sums for easy comparison across scales. The first-order factor scores are highly correlated with their respective mean scale scores (range of $r_s = .95-.99$). The second-order factor scores also are highly correlated with their respective mean scale scores for Narcissistic Grandiosity ($r = .86$) and Narcissistic Vulnerability ($r = .97$). Thus, it is appropriate for practicing clinicians to use the mean scale scores for ease of calculation. Scale and factor descriptions are summarized in Exhibit 6.1, and current

EXHIBIT 6.1

Pathological Narcissism Inventory Scales and Factors

Narcissistic Vulnerability	<i>Self-enhancement failures and disappointment of entitled expectations trigger significant self and emotional dysregulation.</i>
Contingent Self-Esteem (CSE)	Self-esteem is experienced as fluctuating. Self and emotional dysregulation arise in the absence of external sources of admiration and recognition.
Hiding the Self (HS)	Dependency feels weak and shameful. Conceals needs and concerns from others. Disclosure of imperfections evokes anxiety and is avoided.
Devaluing (DEV)	Disinterested in and avoidance of others who do not provide needed admiration. (Devaluing of Others) Shame and self-rebuke over needing recognition from others in the first place. (Devaluing of Self)
Entitlement Rage (ER)	Becomes angry when entitled expectations of self and others are not met.
Narcissistic Grandiosity	<i>Engages in maladaptive and compensatory self-enhancement strategies and holds self-serving beliefs.</i>
Exploitativeness (EXP)	Is manipulative and self-centered in interpersonal relationships.
Grandiose Fantasy (GF)	Is preoccupied with being powerful or achieving great things. Frequently engages in compensatory fantasies of receiving desired respect, admiration, and recognition from others.
Self-Sacrificing Self-Enhancement (SSSE)	Uses purportedly altruistic acts to support an inflated sense of self. Provides instrumental or emotional support to others, but concurrently harbors contempt for those being helped and secretly experiences the relationship as reflecting their own specialness, superiority, and moral goodness.

omnibus models of general personality. Grandiosity exhibits modest positive correlations with the Narcissistic Personality Inventory total score, all inventory subscales, and measures of psychological entitlement. In contrast, Vulnerability is only positively correlated with measures of psychological entitlement (Ackerman et al., 2011; Pincus et al., 2009). Regarding impulsivity, Grandiosity correlated positively with “positive urgency” (positive affect-based impulsivity) and “sensation seeking,” whereas Vulnerability was positively correlated with both “positive urgency” and “negative urgency” (negative affect-based impulsivity; Miller, Dir, et al., 2010). With regard to the five-factor model, Grandiosity is negatively correlated with Neuroticism and Agreeableness and positively correlated with Extraversion (N-, A-, E+); similarly, Vulnerability is negatively correlated with Agreeableness, but it is positively correlated with Neuroticism and negatively correlated with Extraversion (N+, A-, E-; Miller, Dir, et al., 2010). Similar patterns are found in relation to the HEXACO personality model with the notable addition that both Grandiosity and Vulnerability are related to low Honesty-Humility (Bresin & Gordon, 2011). These varied trait associations suggest that narcissistic individuals (at least pathological narcissists) are not merely “disagreeable extraverts” (Miller, Gaughan, Pryor, Kamen, & Campbell, 2009; Paulhus, 2001).

Psychopathology and Externalizing Problems

Grandiosity and vulnerability exhibit distinct and substantively meaningful patterns of correlations across measures of psychopathological symptoms in both normal and clinical samples. Ellison, Levy, Cain, and Pincus (2009) found that Grandiosity is significantly associated with presenting patients' initial scores for mania and violence and that Vulnerability significantly predicted presenting patients' initial scores for depression, psychosis, and sleep disturbance. In a student sample, Miller, Dir, et al. (2010) found that Vulnerability exhibited significant correlations with anxiety, depression, hostility, interpersonal sensitivity, paranoid ideation, and global distress. In contrast, Grandiosity only exhibited a significant negative correlation with interpersonal sensitivity. Using a sample of undergraduates, Tritt, Ryder, Ring, and Pincus (2010) found that Vulnerability was positively related to depressive and anxious temperaments and negatively related to the extraverted, energetic hyperthymic temperament. In contrast, Grandiosity was strongly positively correlated with hyperthymic temperament. In a clinical sample, both Grandiosity and Vulnerability were related to depressive tendencies (Kealy, Tsai, & Ogrodniczuk, 2012). Grandiosity and Vulnerability were also associated with borderline personality pathology in student samples (Miller, Dir, et al., 2010; Pincus et al., 2009). In a clinical sample, Pincus et al. (2009) found that both Grandiosity and Vulnerability predicted suicide

attempts, but, consistent with Miller, Dir, et al. (2010), only Vulnerability predicted parasuicidal behaviors. Importantly, the SSSE Scale appears to be consistent predictor of homicidal ideation and violence (Ellison et al., 2009; Pincus et al., 2009). Only Grandiosity significantly predicted criminal behavior and gambling (Miller, Dir, et al., 2010), and Vulnerability uniquely interacted with child sexual abuse to predict overt and cyber stalking in men (Ménard & Pincus, 2012).

Emotions and Self-Esteem

Narcissistic Grandiosity and Vulnerability exhibit distinct associations with measures of self-esteem, self-conscious emotions, and core affect. Vulnerability is negatively associated with self-esteem, whereas Grandiosity is positively associated with self-esteem (Maxwell, Donnellan, Hopwood, & Ackerman, 2011; Miller, Dir, et al., 2010; Pincus et al., 2009). Vulnerability is positively correlated with shame and hubris, negatively correlated with authentic pride, and unrelated to guilt. In contrast, Grandiosity is positively related to guilt and unrelated to pride and shame (Pincus, Conroy, Hyde, & Ram, 2010). Vulnerability is positively correlated with negative affectivity and envy and negatively correlated with positive affectivity; Grandiosity is only positively correlated with positive affectivity (Krizan & Johar, 2012; Miller, Dir, et al., 2010). Finally, high levels of pathological narcissism predicted strong experimental effects for the implicit priming of self-importance (Fetterman & Robinson, 2010).

*
NB!

Attachment, Parenting, and Early Maladaptive Schemas

Miller, Dir, et al. (2010) found that Vulnerability was associated with attachment anxiety and avoidance, recalling parents as cold and psychologically intrusive, and reporting a history of emotional, verbal, physical, and sexual abuse. Grandiosity was unrelated to these variables. Zeigler-Hill, Green, Arnau, Sisemore, and Myers (2011) examined the distinctions between Grandiosity and Vulnerability regarding early maladaptive schemas. They found that both Grandiosity and Vulnerability correlated positively with the Mistrust and Abandonment schema domains reflecting beliefs that others will abuse, manipulate, or leave them. Grandiosity was also correlated positively with the Entitlement schema domain and negatively correlated with the Defectiveness schema domain reflecting belief that the self is perfect and should be able to do or have whatever it wants. Vulnerability was positively correlated with the Subjugation, Unrelenting Standards, and Emotional Inhibition, and negatively correlated with the Dependence schema domains, reflecting beliefs in unrealistically high standards in a world of important

*

others where emotional expression and interpersonal dependency have negative consequences.

Interpersonal Functioning

Interpersonal problems in NPD, which is limited in scope to grandiosity, reflect a narrow range of vindictive, domineering, and intrusive behaviors (Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009). Pincus et al. (2009) showed that the PNI Grandiosity scales (EXP, GF, SSE) were associated with a similar range of interpersonal problems and that PNI Vulnerability scales were also associated with vindictive (DEV, ER) interpersonal problems as well as exhibiting unique associations with exploitable (CSE) and avoidant (HS) interpersonal problems. Similarly, PNI subscales were meaningfully associated with a variety of interpersonal sensitivities (i.e. being bothered by others' interpersonal behaviors; Hopwood et al., 2011). In a series of studies examining pathological narcissism and response to ego threat (Besser & Priel, 2010; Besser & Zeigler-Hill, 2010), Grandiosity was associated with significant increases in anger and negative affect in response to achievement failures but not in response to interpersonal rejection. In contrast, Vulnerability was associated with significant increases in anger and negative affect mainly in response to interpersonal rejection. Additionally, these effects were further affected by their public or private status; Grandiosity was particularly associated with public ego threats, and Vulnerability was particularly associated with private ego threats.

Psychotherapy

In the only study examining the PNI and psychotherapy, Pincus et al. (2009) found that Grandiosity was negatively correlated with treatment use (telephone-based crisis services, partial hospitalizations, inpatient admissions, taking medications) and positively correlated with outpatient therapy no-shows. Vulnerability was positively correlated with use of telephone-based crisis services, inpatient admissions, and outpatient therapy sessions attended and cancelled. Consistent with the findings of Ogrodniczuk et al. (2009), narcissistic grandiosity was negatively related to treatment use. Using the PNI, we also see that narcissistic vulnerability was positively associated with treatment use, supporting the view that narcissistic patients are more likely to present for services when they are in a vulnerable self-state (Pincus et al., 2009). Finally, both novice and expert clinicians were able to predict a priori PNI associations with established indices of normal personality traits, psychopathology and clinical concerns, and pathological personality traits (Thomas, Wright, Lukowitsky, Donnellan, & Hopwood, 2012). The authors

7

INTERPERSONAL PROBLEMS OF NARCISSISTIC PATIENTS

JOHN S. OGRODNICZUK AND DAVID KEALY

The term *narcissism* commonly evokes the notion of rapt self-involvement rather than a palette of interpersonal interactions. Such narcissistic self-involvement is generally appreciated as having an effect on others. However, knowledge of specific interpersonal behaviors associated with pathological narcissism is not yet widely considered in routine clinical practice. Although clinicians providing general mental health care frequently recognize their patients' interpersonal problems, they may overlook the potential narcissistic function of these behaviors. Certain interpersonal patterns may be indicative of a narcissistic disorder that has yet to be diagnosed. On the other hand, patients clinically identified as suffering from pathological narcissism may obscure, at least initially, the nature and depth of their interpersonal difficulties. Narcissistic pathology is deeply entangled with interpersonal problems, and the nature of narcissism decreases the likelihood of these issues being openly reported on. Narcissistic patients may avoid discussing

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aspects of their psychopathology (e.g., problematic interpersonal behaviors) in an effort to avoid scrutiny and criticism. Alternatively, narcissistic patients might be so oblivious to the effects of their behaviors on others that they simply neglect to report on potentially significant interpersonal problems. Furthermore, the clinician's efforts to explore the patient's role in interpersonal scenarios can evoke either a cantankerous or dismissive response, rather than reflective concern. Getting to know the patient with pathological narcissism therefore involves becoming familiar with a range of interpersonal difficulties, perhaps more so than with any other disorder.

The hand-in-hand nature of interpersonal dysfunction and pathological narcissism is reflected in the clinical aphorism that narcissistic individuals are not necessarily identified by how they feel, but according to how they make others feel. This includes treatment providers; patients who present as arrogant, entitled, and dismissive can leave clinicians feeling befuddled, angry, insulted, and helpless. Such feelings, and the intertwined narcissism and interpersonal dysfunction that engender them, constitute a significant part of the diagnostic and treatment planning process. Recognizing and treating pathological narcissism and its interpersonal dysfunction is extremely important. Although they might appear haughty or indifferent, those with narcissistic problems may suffer tremendously in terms of their core identity, self-esteem regulation, and dysphoric affects. This is particularly so if their actual abilities or achievements are widely out of step with their fantasies and expectations. Narcissistic individuals' interpersonal dysfunction may contribute not only to their own unhappiness but also to difficulties in the lives of their loved ones. Moreover, difficulties interacting with others place narcissistic patients at risk for significant disruptions in their career, social, and family-life trajectories. Stinson et al. (2008) found that substance use, mood, and anxiety disorders are highly comorbid with narcissistic personality disorder. Often it is one of these comorbid conditions that prompts the patient with pathological narcissism to seek treatment. However, Axis I disorders tend to respond poorly to treatment when personality disorders are comorbid (Newton-Howes, Tyrer, & Johnson, 2006). For many patients, addressing narcissistic dysfunction is therefore necessary to obtain relief from other conditions.

This chapter focuses on the interpersonal difficulties associated with narcissistic pathology. In our experience, pathological narcissism as a diagnostic formulation is underrepresented in mental health and outpatient clinic practice, and as such, potential links between problematic interpersonal behaviors and narcissistic dysfunction are often overlooked. We describe the various interpersonal problems associated with narcissistic pathology in order to identify signs of pathological narcissism where it might not otherwise be suspected and to assist with understanding such phenomena when encountered in the

treatment situation. Each problem area is illustrated with a case example; patient identities have been disguised to maintain confidentiality.

INTERPERSONAL PROBLEMS AND PATHOLOGICAL NARCISSISM

Our descriptions are based on the behaviors portrayed by the Inventory of Interpersonal Problems (Horowitz, Rosenberg, Baer, Ureno, & Villasenor, 1988), a widely used instrument designed to assess problems in interpersonal interactions, and on interpersonal theory. We discuss these interpersonal problems as they relate to vulnerable and grandiose features of pathological narcissism (see Exhibit 7.1). It is important to bear in mind that narcissistic vulnerability and grandiosity (as discussed in Chapter 2, this volume) are likely to oscillate or occur simultaneously in an individual patient; therefore, the interpersonal problems discussed under the respective subtypes are best regarded as potentials. Indeed, clinicians can probably expect to encounter mixtures of these interpersonal problems in any given patient with narcissistic tendencies. Their delineation is nonetheless useful for heuristic and diagnostic purposes. Consideration of these interpersonal problems as potentially part of an overall narcissistic disorder can cue the clinician to the underlying pathology. Furthermore, because treatment (and especially psychotherapy) necessitates an interpersonal situation, narcissistic interpersonal problems are inevitably brought directly into the treatment relationship. Understanding these interactional behaviors, which may be reflected in transference and countertransference patterns, is therefore useful in navigating what can sometimes be difficult treatment encounters.

Grandiose Narcissism

Much of the literature has focused on the grandiose type of pathological narcissism. The following descriptions of interpersonal problems are based not only on characterizations of the interpersonal behavior of grandiose narcissistic patients found within the clinical literature but also on the findings of recent studies that have examined the associations between narcissism and interpersonal dysfunction in different samples. These studies (Dickinson &

EXHIBIT 7.1

Interpersonal Problems Associated With Narcissistic Subtypes

Grandiose	Vulnerable
▪ Dominance	▪ Coldness
▪ Vindictiveness	▪ Social avoidance
▪ Intrusiveness	▪ Exploitability

Pincus, 2003; Miller, Campbell, & Pilkonis, 2007; Ogrodniczuk, Piper, Joyce, Steinberg, & Duggal, 2009; Pincus et al., 2009; Pincus & Wiggins, 1990) have found that the interpersonal style of grandiose narcissistic patients is generally characterized by domineering, vindictive, and intrusive behavior. We discuss each of these behaviors in turn.

Dominance

Individuals with narcissistic personality disorder may feel a strong need to exert control over others. This is particularly evident among patients who exhibit grandiose narcissistic trends (Dickinson & Pincus, 2003; Ogrodniczuk et al., 2009). Domineering behavior may take the form of explicit demands for others to obey or conform to the individual's idiosyncratic standards. For example, family members may be forced into complying with strict rules of conduct, having to seek special authority for any kind of exceptional request; one patient of ours insisted that his wife obtain his approval when selecting which outfit to wear each day. In workplace settings, domineering behavior may take the form of a "my way or the highway" kind of attitude when dealing with subordinates or peers: The person's demands are to be followed simply because that is what is desired, without regard for reason or due process. The control exerted in this kind of narcissistic functioning reveals an absence of empathy for those on the receiving end of such behavior. The feelings of others are simply disregarded as the person with narcissistic dysfunction ruthlessly pursues his own agenda. When eventually confronted with the disgruntled reactions of others, dominant narcissistic individuals may be truly surprised, if not indignant, that their efforts have not been appreciated. Dominant behavior is also a blatant expression of grandiosity: They believe that their specialness entitles them to call the shots. However, an additional message is sent out in this kind of interacting: that others are feeble and incapable. In this way, social dominance may reflect a behavioral manifestation of defensive projection: Intolerable self-states associated with weakness are continually assigned to others as the narcissistic individual maintains an authoritative self-representation.

Clinical Example

Mr. C. insisted that his laundry be stored in a separate hamper from other family members' laundry while waiting to be washed, lest any stains spread to his clothes. If his children forgot this rule, he would erupt in fury. In group therapy, he demanded that he be allowed to show up late each session; he argued that his lateness was legitimate because his job was more important than those of other group members.

Although domineering individuals may initially impress others as being confident, take-charge types, those close to them eventually tire of being treated as though they are incompetent or invisible. In the treatment setting, dominance may also be expressed explicitly through demands for the therapist to provide special modifications to accommodate the patient. For example, the patient may insist on a special fee or individualized appointment time arrangements. In group therapy, the patient might clamor for a personal exemption to one of the group rules or norms and may even initially convince group members that this should be provided.

A more surreptitious form of dominance can also enter the treatment in the form of a “sounding board” transference pattern (Gabbard, 2009), in which the patient barely allows the therapist to get a word in edgewise. Although the patient may initially appear to be adhering to the principle of free association, it becomes clear after a while that he or she has little interest in what the therapist might be thinking or feeling, and his or her verbal output serves to control the therapist. The clinician, then, may have feelings of anger, boredom, or disengagement (Gabbard, 2009). The therapist’s countertransference feelings of being excluded may be similar to the feelings of other people in the patient’s life, providing a window into his or her interpersonal dynamics with others. This can be further linked to the patient’s object relations: He or she might have developed a way of controlling and excluding the effects of intrusive early caregivers and now habitually seeks to prevent an anticipated similar experience. Alternatively, such countertransference feelings could reflect dissociated aspects of the patient’s self experience, perhaps related to a disavowed past as a narcissistic object of the parents. In other words, the therapist’s feelings of being shut out may represent an identification with an early object relations configuration involving the patient’s exclusion—a painful sense of shame for needing more of a parent’s attention than was available.

Vindictiveness

Vindictive interpersonal behavior among narcissistic individuals often presents as suspicious, vengeful conduct fueled by envy and resentment. In an acute, activated state this may take the form of narcissistic rage (Wolf, 1988), where the individual feels compelled to enact vengeance to redress what he or she experiences as an intolerable injury to self-esteem. For example, one patient explained that he had to get in the last word if anyone insulted him in any way; anything less than a compensatory strike toward the offending party would be experienced as a soul-crushing humiliation. The envy and shame evoked by the other person being in any kind of “one-up” position might for some narcissistic individuals feel completely unbearable. Shame and envy

are closely linked: The experience of an unrequited need or desire can evoke painful feelings of inferiority, particularly when such need concerns an interpersonal response such as affirmation or admiration. Narcissistic individuals may find it difficult to tolerate another person's possession of an attribute or capacity that they lack. Vindictiveness pertains to shame and envy as a powerful defense against these difficult affect states. Some patients may have a sense of vindictiveness always at the ready, living out a chronic narcissistic rage (Ornstein, 1993/2006). Vindictive responses may take the form of persistent, if sometimes subtle, devaluation as a preemptive guard against envy. In order not to long for another person's possessions or attributes (which would leave the narcissistic patient feeling hungry and weak), they may psychologically spoil whatever is coveted by devaluing it. One patient in group therapy would consistently find ways of offering backhanded compliments to each group member; no one—articulate speakers, successful professionals, parents with children—had anything he would wish for. The more explosive variant of acute, narcissistic rage may also manifest in therapy, as, for example, the patient storms out of the session after unleashing a torrent of verbal abuse onto the therapist.

Clinical Example

Ms. D., a public service administrator, was preoccupied with feelings of resentment toward one of her subordinates, whom she felt was always trying to upstage her. The fact that her junior associate seemed competent and intelligent was bothersome to no end. Vigilant monitoring of this employee's performance for any sign of weakness began to dominate her work: She felt certain that he was indeed a fraud. In group therapy, she seemed to sulk whenever another member received attention or positive feedback from the group. In time it was revealed that, once outside the building after group sessions, Ms. D. would gather some of the members together to disparage the therapist.

Some patients with narcissistic tendencies seem to enter the consulting room with a vindictive agenda, ready to immediately assign fault to the therapist for a host of perceived faults or injuries that have befallen the patient in the past. Such patients may have felt other care providers to have been incompetent and may unconsciously seek to punish the current clinician for the perceived or real deficiencies of others. They may approach the consultation in a "guns blazing" manner that masks the vulnerable affects associated with having been disappointed by others. This stance may represent a

simultaneous disavowal of having been hurt and a preemptive effort at avoiding further pain by becoming the one who hurts. This defensive maneuver is thus enacted through verbal devaluation of the therapist or actual sabotaging of treatment efforts. Indeed, it is conceivable that vindictive interpersonal processes might account for part of the substantial treatment drop-out among narcissistic patients. By unilaterally terminating therapy, the patient may be enacting a vindictive fantasy against the therapist, either for perceived wrongdoings or for anticipated disappointments.

Other patients might bring vindictive behavior into the clinical situation more gradually in the form of insidious devaluation of the therapist, subtly expressing the belief that the therapist is somehow incompetent or inferior. Gabbard (2009) elaborated on the contemptuous transference pattern encountered with some narcissistic patients and the consequent countertransference challenges faced by clinicians. As Gabbard noted, contemptuous transference often comprises a defensive effort against envy of what the therapist is perceived to possess, including the capacity to be helpful to the patient. Vindictive behaviors might also emerge in the wake of what the patient experiences as devaluation by the therapist. For some narcissistic patients, even well-meaning interventions may be felt to be insulting or belittling. A strike back might be deemed necessary by the patient in order to restore a stable sense of self. One group therapy patient of ours felt so exposed and humiliated by any intervention, whether interpretive or the setting of basic group norms, that denigration of the group therapists seemed to become the focus of his attention in therapy. His vindictive efforts escalated to the point of sabotaging his treatment. Kernberg (1984, 2007) described patients with malignant narcissism whose self-esteem seems to be enhanced through the expression of aggression, including the sadistic defeat of the therapist. Severe vindictiveness in the form of malignant features combined with antisocial traits could present a contraindication for treatment.

Intrusiveness

Intrusive interpersonal behavior often involves exhibitionistic displays that encroach on other people's personal space. A feature of the grandiose side of the narcissistic spectrum, intrusiveness may comprise behaviors intended to cultivate a sense of superiority or to elicit admiration from others. Although the exhibitionistic behavior may demonstrate legitimate talents or skills, its deployment may be consistently ill-timed and lacking in consideration for how others might actually experience it. For example, one woman, an able singer, felt compelled to sing aloud at her daughter's music recitals, oblivious to her daughter's embarrassment at being upstaged. Intrusive behavior can also consist of insistence on one's

specialness. Frequent name dropping of important people with whom the individual had a minor connection is one such example. Seemingly casual hints of one's specialness might be woven into conversations, or activities might just happen to be routinely organized around the individual to garner admiration. Individuals with this intrusive pattern may also show a disregard for personal boundaries, feel free to offer unsolicited wisdom to others, or take for themselves what they feel entitled to. The intrusive narcissistic individual is likely to fail to appreciate that his or her behavior can engender superficiality and distance in relations with others, rather than admiration and affection.

Clinical Example

Mr. E. had a history of being terminated from jobs, despite an impressive sales record. He felt that his colleagues could not handle that he was "the best in the business" and had him fired out of spite. He later acknowledged that female colleagues had complained about his habit of flirtatious advances and sexual innuendo. He consulted with a female therapist about his reaction to the latest rejection. At times during the sessions, he seemed to focus on describing his various accomplishments. At other times, Mr. E. would visually scan the therapist's body, ask personal questions, and make inappropriate attempts at humor (e.g., "What's your husband like? I bet you wear the pants in the family").

Intrusive behavior may be one of the more persistent interpersonal patterns of narcissistic patients. For patients who completed an 18-week psychiatric day treatment program, intrusiveness was the only interpersonal domain to not show a significant change by the end of treatment (Ogrodniczuk et al., 2009). Group therapy presents a range of opportunities for narcissistic patients to act out intrusive and exhibitionistic behavior. They might begin the session with a long-winded, dramatic tale of their latest exploits, oblivious to the pressing needs of other members to explore issues of conflict and distress. When other group members do speak about some kind of personal tragedy, intrusive patients may shift the focus onto themselves with over-the-top tears of "sympathy." They might proffer unsolicited hugs to members and invite them to call after the session, ignoring the boundaries and norms set up by group leaders, who seem callous compared to the fervent altruism displayed by these patients. Boundaries may be likewise blurred in the individual treatment setting; patients may prefer to treat the clinician more like a friend than a therapist. Their priority in therapy may shift from exploration to

cultivating admiration as they regale the therapist with examples of their accomplishments. Such a pattern may underscore patients' disavowed longing for the therapist's love and approval. Similarly, a profound curiosity and inquiry into the therapist's life can also denote such yearnings while shifting focus away from patients' weaknesses as they present themselves in more of a "friend" role.

Vulnerable Narcissism

Most standardized assessments of narcissism have emphasized the grandiose variant described in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.; text rev.; *DSM-IV-TR*; American Psychiatric Association, 2000). Consequently, there is a lack of empirical data from clinical patients regarding the interpersonal problems associated with vulnerable narcissism. This could contribute to an underestimation of the relational and behavioral sequelae of this narcissistic subtype. The comparatively less dramatic nature of vulnerable narcissistic interpersonal behaviors can also potentially obscure their identification as markers of significant psychopathology. A key difference with the vulnerable subtype is a tendency to feel a high degree of distress regarding their interpersonal relationships, whereas grandiose narcissistic individuals typically are not overly concerned about this issue (Dickinson & Pincus, 2003). Using the newly developed Pathological Narcissism Inventory (see Chapter 6, this volume), which assesses aspects of vulnerable narcissism, Pincus et al. (2009) found that vulnerable narcissism was associated with cold, avoidant, and exploitable interpersonal behaviors. Further empirical research is required to clarify the associations between vulnerable narcissism and these problematic interactional patterns.

Coldness

Some patients with a vulnerable form of narcissism may be most recognizable in terms of what they lack: genuine emotional warmth. Because of feelings of inner emptiness, envy, or anxiety regarding relationships, these patients can tend to be distant and aloof. Their coldness may function as a form of disavowal of normative needs for closeness. Yet, at the same time, they may hold a covert attitude of entitlement with regard to receiving love and admiration. Although vulnerable narcissistic individuals report high interpersonal distress (Dickinson & Pincus, 2003), their defenses often lead them to attribute an external causality for this. For example, one patient felt wounded whenever his wife did not show her appreciation of him, while at the same time denying the importance of her appraisal. He manifested an aloof stance toward her, reflecting a denial of his vulnerability, thereby construing his wife as the needy, weakened partner.

Clinical Example

Ms. F. complained of a staid marriage and lackluster social interactions. She had no idea about causes of these problems. In her therapy, she showed a tendency to march in and out of the consulting room with almost no greeting to the therapist. She sat rigidly with minimal eye contact. Over time the therapist felt disengaged and frequently flirted with the wish to terminate the therapy prematurely.

In the treatment situation, lack of interpersonal warmth may be revealed in the patient's nonverbal behavior. Patients may be capable of verbalizing thoughts, feelings, and issues to work on in therapy, but their demeanor may be aloof. Some patients with this interpersonal style might have difficulty with eye contact and with the normative friendly gestures of social interaction. Other such patients may be capable of these ordinary and customary social behaviors but may strongly resist the "real relationship" (Greenson, 1972) aspect of the treatment situation. They may view the therapist as simply "doing a job" rather than being capable of genuine warmth. Attempts to explore the transference relationship may yield the response, "What relationship?" In this sense, interpersonal coldness may manifest a variant of the sounding-board transference pattern, although without the self-aggrandizing quality. The therapy situation may be construed unilaterally as a service—akin to visiting the laundromat—rather than as a relational experience. This is often reflective of an incapacity to depend on others, defending against deeply walled-off yearnings for love and merger, the emergence of which could be perceived by the patient as dangerous or destabilizing (Kernberg, 1984). For the therapist, prolonged exposure to this kind of coldness in the consulting room can lead to a fatigued countertransference characterized by boredom and feelings of futility, perhaps following failed attempts at enlivening the therapeutic encounter through various interventions.

Social Avoidance

NB
Socially avoidant behavior consists of cautious, inhibited, and limited interactions with others. Often this includes actual retreat from social interactions. Dickinson and Pincus (2003) found that in reflecting self-conscious concerns about being approved of by others, narcissistic social avoidance shares some overlap with avoidant personality features. However, they noted that whereas (nonnarcissistic) avoidant individuals fear lack of acceptance, vulnerable narcissistic individuals fear lack of admiration and narcissistic supply. In this sense, narcissistic avoidant behavior may forestall severe dysphoria or

“fragmentation” (Kohut & Wolf, 1978) entailed in the disappointment of entitled interpersonal expectations. Social gatherings may be experienced as arenas for potentially humiliating encounters. For example, going to a parent–teacher interview could leave the patient in a dysphoric tailspin for days if the teacher did not recognize the child’s talents (which may be experienced as direct reflections of the parent). Anticipating such encounters can evoke feelings of undue stress. Ironically, by vigilantly steeling themselves against potential insults, fragile narcissistic individuals risk creating a self-fulfilling prophecy where social rigidity and unease actually elicit subtle rejecting behaviors from others.

Clinical Example

Mr. G., director of a health care facility, maintained a “closed door policy” at work. He sought to limit his interactions with subordinates as much as possible, lest they say anything negative to him. Any criticism was felt as a massive exposure of his weakness, following which he would ruminate for several days on how he could buttress himself against further attacks. He was frequently absent from group therapy, often following a session in which he received feedback from a group member.

Gabbard (2009) described the phenomenon of fear of humiliation as a central transference pattern in psychotherapy with vulnerable narcissistic patients. Where such patients try to avoid social interactions that carry the potential for humiliation, they may experience therapy as a profound exposure of their inadequacy and shame. The very act of being a patient is felt as a signal of a serious personal defect. Consequently, the transference associated with social avoidance may revolve around the patient’s sense of embarrassment or personal injury. This can be manifest in a vigilant stance toward the therapist, scanning for potentially shaming words or actions. Clarifying comments and interpretations, for example, may be perceived by the patient as intolerable insults that seem to “rub it in” that the therapist and patient are not on an equal playing field. Kohut (1968) developed the construct of the mirror transference through discovering that certain narcissistic patients could not tolerate anything beyond a verbal reflection of essentially what they had just said: Anything more seemed intrusive and enraging to the patient, presumably because it activated narcissistic shame and envy.

Exploitability

The exploitable domain refers to difficulty expressing anger toward others and readiness to go along with others’ wishes. Therefore, a sense of being taken

advantage of is often a feature of this interpersonal domain. In discussing the vulnerable subtype of narcissistic personality disorder, Cooper (1988/2006, 1998) has emphasized the presence of masochism in contrast with many of the DSM diagnostic markers for the disorder, noting that the vulnerable narcissist “is more exploited than exploiter” (Cooper, 1998, p. 70). Enacting the role of a suffering individual allows for a secret and paradoxical exploitation of social relatedness: deriving a sense of specialness out of relentless “doing for” others without reward.

Cooper noted that this form of narcissistic masochism entails self-defeating interpersonal interactions in order to maintain complex fantasies related to both grandiosity and weakness. Persistent interpersonal defeat—unconsciously “arranged”—provides a covert, defensive extraction of satisfaction from being mistreated. This form of interpersonal dysfunction may be particularly difficult to assess and explore, in part because of patient indignation (“Why am I always being picked on?”) combined with a strong need to consciously regard their actions as wholly altruistic. After having described their efforts at helping others, however, they may then complain that other people seem to “use” or take advantage of their kindness. For some patients, this type of interpersonal scenario may become a recurring theme, representing a self-regulatory compromise between seeking admiration (and thus not true attunement to others’ needs) and holding on to a sense of injustice (Campbell & Baumeister, 2006).

Clinical Example

Ms. H. served on her church’s planning committee, led their fundraising campaigns, and taught Sunday school. She complained bitterly to the therapist about being “roped into” too many responsibilities and expressed the conviction that no one recognized the burden involved in “going along” with these requests. In therapy, she maintained an exceedingly agreeable stance toward the therapist, almost never indicating the slightest irritation. During the course of a session, the therapist offered a kind remark. The patient replied, with genuine anger, “You’re too damn nice. Sometimes I wish you’d just slap me across the face and tell me straight up what I should do.”

Exploitable interpersonal dysfunction may be difficult to discern in the treatment situation, at least initially. This has to do with the desirability of agreeable behavior, reflecting an ordinary facilitative transference (Freud, 1912) considered important for a working alliance. In time, however, it may become

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AFFECT REGULATION AND MENTALIZATION IN NARCISSISTIC PERSONALITY DISORDER

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Pathological narcissism is a complex, multifaceted phenomenon that encompasses a wide range of levels of functioning (Pincus & Lukowitsky, 2010; Ronningstam, 2009). Patients diagnosed with a narcissistic personality disorder (NPD) are a subset of narcissistic individuals presenting themselves as grandiose and arrogant. In this chapter, we examine an aspect of the psychological functioning of this group of patients that has been somewhat neglected in clinical writings and research, namely, affect regulation and mentalization. We think that a closer look at some nondeclarative mechanisms of affect regulation might shed some light on phenomena that arise in the psychological treatment of patients with NPD.

In a nutshell, our affect regulation-based model integrates a psychoanalytic conceptualization of mentalization, emotion theory, and a neurocognitive understanding of memory. It posits that early experiences of helplessness and denigration lead to feelings of shame that are concretely experienced and too painful to bear because of their traumatic nature. The

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narcissistic solution to the regulation of these experiences is to build an inflated impression of self-worth in order to avoid unmentalized feelings of inadequacy as well as internalized self-denigrating attacks. Moreover, in an attempt to circumvent future potential interpersonal experiences of humiliation, learned action-based denigrating relational patterns are actively adopted and maintained in relationships with others. We propose that any successful psychotherapy facilitates mentalization and improved emotion regulation by modifying the proceduralized narcissistic coping solutions through a convergence of means: the exposure to painful affective states, their increased tolerance, and the extinction of narcissistic coping mechanisms; the instauration and maintenance of an empathic and benevolent interpersonal ambiance, which help create new interpersonal and intrapersonal procedures; and the labeling and articulation of emotional experience, which increase the capacity to differentiate painful mental states and inhibit compensatory strategies for emotional regulation. The rest of the chapter “unpacks” the main elements of this dense summary and draws more explicit implications for the psychotherapy of NPD.

HOW CAN PATHOLOGICAL NARCISSISM BE UNDERSTOOD IN TERMS OF AFFECT REGULATION AND MENTALIZATION?

In the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), the NPD represents a prototype of pathological narcissism. Grandiosity is the essential feature of the disorder (Gunderson, Ronningstam, & Smith, 1995), and it clearly underlies more than half the diagnostic criteria (grandiose sense of self, fantasies of unlimited success, belief in specialness, requirement of admiration, sense of entitlement). Another important feature is a type of interpersonal antagonism expressed through callousness and denigration (exploitativeness, lack of empathy, envy, and arrogance). In extreme forms, such as in malignant narcissism (Kernberg, 1984; Ronningstam, 2009), this antagonism can reach levels found in antisocial personalities. Although it is somewhat secondary in the NPD description, this antagonistic feature might be underestimated in the DSM definitions of NPD (Westen & Shedler, 1999).

Grandiosity and Arrogance

We consider two important features of NPD, grandiosity and arrogance, to be broad regulatory measures aiming at countering intense feelings of helplessness and shame, one mostly intrapersonal (inflated sense of self-worth)

and the other mainly interpersonal (denigration of others). The intrapersonal–interpersonal distinction is obviously relative because grandiose exhibitionism and entitlement, for instance, can easily have an interpersonal impact (Pincus & Lukowitsky, 2010), but it brings some clarity to our presentation. Throughout this chapter, we focus on the grandiose version of the NPD. Other “shyer” or more vulnerable presentations of pathological narcissism have been described. Because pathological narcissism is currently conceptualized as manifesting both grandiosity and vulnerability in oscillation (Ronningstam, 2009), our discussion of the core vulnerability of NPD and its narcissistic regulatory solutions should be relevant to all forms of pathological narcissism.

Affect Regulation and Mentalization

We maintain that affect regulation is not restricted to mood regulation. Because affect is generally defined as an inclusive category for a variety of valenced (pleasant–unpleasant) motivational experiences, including emotion, mood, and drive, affect regulation has a wider application than mood regulation. In NPD, affect regulation also subsumes the regulation of shame. Our basic assumption is familiar to researchers and clinicians: Grandiosity and arrogance are strategies for “bypassing” helplessness and shame. However, our perspective on affect regulation differs by emphasizing the role of nonsymbolic mental contents and processes and their mentalization. We define *mentalization* as the transformation of an affect’s core somatic and behavioral components (forming its basic action tendency) through the intervention of a combination of mechanisms, including nonsymbolic relational processes and symbolic operations such as representation and symbolization (Lecours, 2007; Lecours & Bouchard, 1997). At its lowest level of mentalization, an affect is experienced as a bodily event with no significant subjective meaning. With further processing, it can be known as a concrete psychological phenomenon, felt as “real” and intolerably painful, needing thus to be dealt with urgently. When an affect is well mentalized, it is tolerated, felt, and owned as a subjective experience; it has a symbolic “as-if” quality and can be reflected on or metacognitively elaborated (Fonagy, Gergely, Jurist, & Target, 2002; Lecours & Bouchard, 1997; Semerari et al., 2003). In another highly compatible vernacular, nonsymbolic or unmentalized aspects of affect regulation can be construed as governed by nondeclarative memory processes and structures (Lecours, 2007). We thus reformulate some well-known hypotheses about NPD in terms of emotional memory (classical conditioning), proceduralized attempts to regulate it (through thoughts or actions), and interpersonal ways of being, again involving emotional and procedural memory.

Nondeclarative Memory Systems

We begin with a refresher on nondeclarative memory systems. Classical conditioning, or emotional memory, and procedural memory are two forms of nondeclarative memory, that is, a memory that cannot be consciously "declared" (as opposed to forms memory that can become conscious such as autobiographical or semantic memory). *Classical conditioning is an associative memory* in which, as in the famous Pavlovian experiment, a neutral sensory perception (bell) is associated with another sensory stimulus (food), which spontaneously evokes a somatic (or emotional) response (salivation); after pairing the two stimuli, the neutral stimulus becomes capable of unconsciously triggering the somatic response (the bell triggers salivation). *Procedural memory is the nonconscious memory of how to do things* (e.g., how to ride a bicycle). With practice, sequences of actions can be executed automatically, without the intervention of a conscious recall of the required steps. Other nondeclarative memory systems exist, but these two are the most relevant to psychotherapy (Davis, 2001).

Contrasting Models of Mentalization

Our model of mentalization differs from Fonagy et al.'s (2002) conceptualization of mentalizing and reflective functioning in many ways. Our model was initially inspired by early French psychoanalytic contributions on mentalization, which put emphasis on the transformation of affective-drive somatic derivatives through the acquisition and organization of mental representations (Luquet, 2002; Marty, 1991), whereas Fonagy's model posits the acquisition of a theory of mind through the development of cognitive abilities facilitated by a secure attachment context. Consequently, and more importantly, we see the formal characteristics of the different types of unmentalized experiences as stemming from the properties of the memory systems interacting to shape an affective response and not as a return to modes of thinking anterior to the acquisition of the fully developed mentalization ability. For instance, Fonagy understands psychic equivalence observed in adults as such a retrogression. Psychic equivalence, characterized by a mind-world isomorphism making subjective experiences feel too real and alternative perspectives rare or nonexistent (Bateman & Fonagy, 2006), is for us the consequence of the activation of emotional memory networks in their sensorimotor form, triggered with the felt urgency and actuality typical of high arousal conditioned emotional memory (e.g., the absolute conviction of the imminence of danger in the triggering of a phobic response).

This difference of focus brings about differences in the conceptualization of change. Since emotional and procedural memory systems are impermeable

to direct verbal–symbolic action because of their heterogeneity, we see the modification of nondeclarative structures in personality disordered patients as occurring principally through nondeclarative mechanisms, as opposed to Bateman and Fonagy’s (2009) mentalization-based treatment, which “aims to strengthen patient’s capacity to understand their own and other’s mental states in attachment context” (p. 1355) in order to address multiple issues related to affect regulation. However, although Bateman and Fonagy (2009) concentrated their therapeutic efforts on improving what they called *explicit mentalization* (declarative components of mentalization), their actual treatment also offers many avenues for the strengthening of what they referred to as *implicit mentalization* (nondeclarative components of mentalization). For instance, basic mentalizing techniques such as “stop, listen, look” or “stop, rewind, explore” exercise the patient to pay closer attention to and explore his or her way of thinking about mental states and emotions, which unavoidably end up modifying patients’ (procedural) ways of acting (here, focusing attention, act curious, explore) toward their own or others’ emotions (Bateman & Fonagy, 2006). In addition, other general relational factors (e.g., offering support, empathy) produce changes in nondeclarative structures in mentalization-based treatment.

WHAT IS PATHOLOGICAL NARCISSISM TRYING TO AVOID OR COMPENSATE?

Research on the etiology of NPD is remarkably scant. As is the case for all major mental disorders, the “making” of a clinically significant NPD involves the interaction of temperamental factors, problematic developmental-attachment issues, and early adverse or traumatic interpersonal events. We concentrate on the shaping of affect regulation and mentalization, clearly at the intersection of the etiological factors enumerated above, in order to provide a fresh look at the construction of the intrasubjective and intersubjective regulatory strategies of NPD patients.

Shame and Helplessness

Shame is often presumed to be the central affect of narcissistic pathologies (Broucek, 1982; Morrison, 1986; Wurmser, 1981). In its fully developed form, shame is the painful feeling of having one’s self exposed to the disapproving eye of another. At optimal “doses,” shame has an adaptive value: It reinforces social cohesion through conformity to shared ideals, or it fuels motivation to change (Izard, 1991). However, shame can also have a disorganizing impact on the self when it occurs too early during development (when the self is vulnerable and highly impressible), too frequently (e.g., chronic or systematic

devaluation), or too intensely (e.g., in abuse). It has been suggested that, prior to the emergence of shame proper (i.e., 12 to 18 months of age: Lewis, 1982), when negative affects are undifferentiated, a traumatic event can lead to a profound state of distressed helplessness, constituting a precursor to shame (Krystal, 2000). A perceived failure to initiate, maintain, or extend a desired emotional engagement with a caregiver has also been seen as provoking an early form of shame response (Broucek, 1997). Hence, the aspect of self functioning that is disrupted by shame varies according to the level of development achieved when self-thwarting occurs. For instance, systematic shaming of a child's elated exhibitionistic bursts at Mahler's practicing period (Schor, 2003), when language development has not yet occurred, is more injurious to the future adult's self organization and self-esteem than, say, a boy being ridiculed whenever he puts on a precocious "manly" attitude during his oedipal phase. Common to all experiences of shame is a painful feeling or displaying of a lack of competence, efficacy, adequacy, or agency. However, a range in the severity or pathology of shame experiences is postulated (Ciccone & Ferrant, 2009): from a shame about being or existing (Roussillon, 1999; Wurmsler, 1997), based on a primary state of helplessness, to a shame about more mature self-states, such as one's virility in the example given above, with corollary levels of self-fragmentation and depletion. For the rest of the chapter, we use the term *shame* in reference to all forms of shame and its less differentiated precursors. As for NPD, shame is thought to emerge from the earlier experiences of helplessness and intersubjective inefficacy, resulting in a more borderline level or identity-defining feeling of inadequacy (e.g., "What is my value as a human being?"), in contrast to later experiences of shame, at the heart of more neurotic narcissistic preoccupations, where, for instance, doubts about one's sexual powers take the forefront (e.g., "What is my level of desirability as a man?").

Nondeclarative Aspects of Shame

Overwhelming experiences of shame are intolerable for the child. Just as intense fear can lead to a posttraumatic stress disorder, intense shame can have a traumatic impact. These disorganizing forms of shame are essentially registered as nondeclarative, classically conditioned emotional memory (for a discussion of traumatic fear, see LeDoux, 1996). Classically conditioned emotions are encoded in a richly embodied form (the amygdala-hypophysis connection with rapid and direct stimulation of motor activity and somatic activation), and they are tightly associated with the sensory information that is perceived during the emotional event. This bodily connection, because of its sensorimotor nature, is thus basically unmentalized. The conditioned sensory information acts as a trigger to the full conditioned emotional reaction.

LeDoux (1996) argued that this conditioned memory, linking sensory data to emotional activation, is indelible. Emotional reactivity is reduced, not by "forgetting," but by an active inhibitory process named extinction: When the conditioned stimulus is presented but not followed by the initial consequence, the emotional response is reduced. To illustrate, if a child is ridiculed when he expresses sadness, thus provoking shame, the experience of sadness is associated with shame. If this shaming is systematic, the child learns to not show sadness; in effect, he becomes phobic of sadness (McCullough et al., 2003). If, however, the child shows sadness and this expression is no longer followed by denigration, the fear of suffering shame is reduced and the avoidance of sadness is extinguished. NPD patients essentially become phobic of whatever behavior has been shamed or treated as weak in order to avoid the intolerable shame-related affects. Whenever the shame-inducing stimulus is presented to the individual, the shame response is triggered and avoided.

In addition to learning to associate sensory data to an emotional reaction, the individual also learns how to act with himself and with shame-arousing others. The classical psychoanalytic formulation of such a process is the internalization of the relationship in the form of self and object representations. The unattuned and denigrating relationship is learned as a whole through observation and is encoded into behavior patterns. That is, while children are shamed, they learn how to shame themselves and others. This embodied observational learning, which probably operates through the intervention of mirror neurons (Gallese, 2009), is compatible with object relations formulations: An individual can at times act the role of the victim and at other times the role of the aggressor. However, what is not sufficiently acknowledged in these models is the procedural and action-based nature of the learning. Thus, using his early interpersonal interactions as models, the NPD patient learns to scorn and criticize himself and others. These actions, often mental actions that manifest themselves as self-derogatory internal remarks, are learned as ways of being with oneself and others, and they are associated with the shame-provoking stimulus. NPD patients harshly condemn themselves for having been needy or vulnerable, for instance, but at other times they are the ones denigrating others for being needy or vulnerable. These learned reactions of affect phobia and of denigrating vulnerability "on sight," either in oneself or in others, are very likely important contributing factors to the lack of empathy found in NPD patients.

HOW ARE THE NARCISSISTIC COPING SOLUTIONS FORGED?

Early experiences of abuse, misattunement, and denigration can elicit very painful states of shame-related affects. The avoidance of these unmentalized affects is requisite to the survival of the child's sense of self-integration.

Psychoanalytic models have described a range of defense mechanisms used by NPD patients for warding off a profound sense of inadequacy: splitting, dissociation, and the creation of a grandiose self. These mechanisms can be reformulated in terms of nondeclarative, mental procedures that can be associated with shame-inducing interpersonal situations and automatically triggered in order to avoid the anticipated painful affect (Gillett, 1996; Westen & Gabbard, 2002a). Are they regulatory or defense mechanisms? The difference is a question of conceptual emphasis: Although defense mechanisms can be conceived as unconscious affect regulation mechanisms, to call them "defense" mechanisms implies the operation of a protective agency such as ego or self. The bottom line is that these strategies serve the function of avoiding unbearable shame. Thus, grandiosity can become an automatically activated affective structure to suppress self-depletion, that is, the pleasurable elation-saturated fantasy of omnipotence can be recruited to cover up the profound pain of unmentalized shame. In other words, NPD patients grow "addicted" to omnipotence as a coping solution for the regulation of shame. The more pervasive the state of shame, the more exaggerated and chronic becomes the attempt to undo the experience of self fragmentation.

Arrogance can also become proceduralized as a means to establish a dominant relationship with others, as a kind of "preventive strike" against the chance of being humiliated or domineered. "Offense is the best defense," the NPD patient might say. Arrogance is modeled from early abuse, with a turning of passivity into activity, a taking control over, and undoing of, intolerable helplessness in the presence of an overbearing figure. Psychoanalytic formulations have designated this mechanism as identification to the aggressor.

Grandiosity as a way of being (acting with self and others) can also be learned through reinforcement. Mitchell (1988) showed that grandiosity can become a type of relational engagement, based on early significant relationships that value narcissistic involvement. For example, grandiosity is reinforced as an essential mode of interacting with a grandiose parent insisting on being mirrored by his child's accomplishments. Here, not being grandiose would mean risking being abandoned and thus being faced with unbearable affects.

Thus, to regulate self-depletion, a series of mental and behavioral actions can become registered as procedural memory. All interpersonal encounters evoking "vulnerable" feelings such as dependence, neediness, envy, inferiority, or helplessness activate the narcissistic "defense" or regulatory solution. When these regulatory mechanisms are not successful in creating the impression of mastery, superiority, or competence, the unarticulated deflated self affect is experienced in a vague depressive affect, which explains why grandiosity can be unstable and can oscillate with depression, as reality inevitably contradicts the narcissistic illusion of perfection.

HOW CAN NONDECLARATIVE REGULATORY SOLUTIONS BE REDUCED OR MODIFIED?

Having recognized the issues of shame regulation described above, one might wonder how they differ from mainstream psychoanalytic formulations of NPD pathology (self-structure, object relations). Differences emerge when the properties of nondeclarative memory structures and processes are fully taken into account and their implications for the psychological treatment of NPD made more explicit.

Some psychoanalysts have begun addressing the contribution of nondeclarative memory systems to theories of change (Boston Change Process Study Group, 2007; Davis, 2001; Fosshage, 2005; Westen & Gabbard, 2002a, 2002b). As a heuristic shortcut, one can associate relational curative factors to nondeclarative memory systems and self-awareness to declarative systems. Some have discussed the fundamental heterogeneity of nondeclarative and declarative memory systems (see Fosshage, 2005): They operate independently, in parallel, and are governed by different cerebral structures. One very important implication for psychotherapy is that declarative processes cannot directly modify nondeclarative structures. In other words, interpretation cannot directly alter emotional-associative or procedural structures. Think of how phobias are resistant to the awareness of their irrationality or how one cannot learn not to overly slice a tennis backhand just by knowing that it is not appropriate. How the declarative and nondeclarative systems are precisely related is still open to speculation.

How, then, can we modify nondeclarative structures in psychotherapy? Essentially through nondeclarative mechanisms. Self-awareness can temporarily inhibit a nondeclarative sequence, but it cannot directly modify it. Again, think of the momentary relief and freedom from the automaticity of unconscious process that is provided by a meaningful interpretation; the change does not last and the psychoanalytic theory of technique informs us that it has to be "worked through" by further interpretive work. This inhibitory interaction has been documented by McClelland in his work on implicit and self-attributed (explicit) motives (McClelland, Koestner, & Weinberg, 1989). Implicit (nondeclarative) motives are the "default" guiding forces, they motivate spontaneous and automatic behavior, but when an explicit (declarative) motive is activated, the latter dominates motivation as long as it is present in working memory. When it leaves conscious awareness, implicit motives take back the lead. Again, to illustrate, the overly sliced backhand is operative in a live tennis match. However, if we remind ourselves to bring the racquet down and use an upward swing, the slice is suspended and replaced with a flat or top-spin backhand. When play resumes and the instructions for a good backhand fall out of awareness, the heavy slice returns. However,

declarative systems do matter; the following section explains how self-awareness can contribute to the creation of new nondeclarative structures.

Changing Nondeclarative Narcissistic Structures

We suggest that three broad "fronts" have to be addressed simultaneously for an optimal reduction of nondeclarative narcissistic regulatory strategies.

Building Affect Tolerance

Tolerance for shame and vulnerable emotions has to be increased. This essentially occurs through the extinction of the shame and fear-of-shame responses through classical learning mechanisms. Extinction is achieved through the patient's repeated exposure to shame and vulnerable self-states. Exposure is a ubiquitous phenomenon in successful psychotherapy, whatever the therapist's theoretical persuasion. An active, empathic, and compassionate exploration of the patient's painful emotional states progressively and "silently" builds the capacity to tolerate vulnerable affects.

Reducing Self-Denigrating and Creating Benevolent Procedures

Procedural ways of denigrating self and others have to be inhibited, and benevolent ways of being with self and others have to be created. These changes usually take place in the "internalization" of a more empathic and compassionate relationship. In other words, new ways of interacting with self and others are created, and they eventually dominate at the end of a successful treatment.

The transformation of emotional memory and procedural knowledge takes time because new structures can be created only through direct exposure or practice. In addition, maladaptive structures do not disappear, so new permissive structures have to be built over them, and they have to eventually predominate if they are to guide experience and behavior. This is especially true of NPD individuals who have been systematically devalued over the years, thus having thoroughly rehearsed their pathological strategies for avoiding shame.

Expanding Self-Awareness

Self-awareness has to be expanded. Essentially, the creation of more complex declarative meaning networks builds an increasingly efficient and constant inhibitory effect on automatically triggered nondeclarative (emotional and procedural) systems. For instance, if an NPD patient learns that he wrongly anticipates being ridiculed for showing sadness, even with his partner who welcomes such reactions, he eventually becomes able to suspend his tendency to mock sadness long enough to expose himself to being sad

without being scorned. Self-knowledge can thus contribute to the creation of new more adaptive nondeclarative structures; in this case, more tolerance of sadness and a more assertive attitude toward the expression of sadness.

Implications for the Psychological Treatment of NPD

When considering the process of psychotherapy with NPD patients more specifically, the following considerations can usefully guide therapeutic interventions. The general goal of psychotherapy with NPD patients, in terms of affect regulation and mentalization, is to help patients increase their tolerance of shame so that they can further mentalize it. Two factors impede the realization of this objective: the painfully traumatic and unmentalized nature of shame-related affects, forcing their avoidance; and the regulatory procedures created to ward off these affects (grandiosity and arrogance). These two factors are intertwined and can be regarded as the two sides of the same coin: Shame is "too hot to handle" and so has to be avoided; the encapsulation (dissociation, splitting) of shame hampers its mentalization. That is why we feel that the building of shame tolerance has to be worked on concurrently with the reduction of the narcissistic procedures. However, the suspension of narcissistic regulatory mechanisms requires sufficiently robust declarative resources (executive functions, ego strength) so as to achieve a truly inhibitory effect on procedural structures.

Primacy of Nondeclarative Curative Factors

Because affect intolerance, grandiosity, and arrogance are based on nondeclarative structures and mechanisms, and because declarative structures for affect regulation are usually weak in these patients, we think that therapeutic efforts should place more attention on nondeclarative relational factors in the psychotherapy of severely unmentalized pathologies such as NPD, especially at the beginning of treatment when affect tolerance is at its lowest. The mentalization of nondeclarative structures is usually achieved in psychotherapy through the concurrent action of bottom-up processes (working on nondeclarative structures to facilitate the use of declarative mechanisms) and top-down processes (using declarative mechanisms to reduce nondeclarative structures). With severe personality disordered patients, the first kind of processes has to be preponderant. Otherwise, without sufficient affect tolerance, interventions aiming at increasing self-awareness are experienced as threatening the patient's fragile sense of self (either by opening the door to painfully unmentalized affects and the consequent self-fragmentation, or by being concretely misread as critical or denigrating remarks by the therapist). Thus, we suggest that interpretations have to be preceded by a "preparatory

work” on nondeclarative structures for NPD patients. Again, this is not a new idea (see, e.g., Bernstein, 2010), but its formulation in terms of declarative and nondeclarative mechanisms is. By contrast, neurotic patients, because of their robust declarative resources and the less severely pathological and less prevailing nondeclarative structures, would benefit more from an emphasis on top-down processes in psychotherapy (Lecours, 2007).

Examples of Relational Ways of Changing Nondeclarative Structures

Here are only a few examples of how the relationship with the therapist acts on nondeclarative structures. In these instances, (inter)action matters more than content in the therapeutic exchange. First, the therapist’s manifest openness to and explicit empathy toward vulnerable affects serves as a model for the patient: The therapist values vulnerability, which serves as the basis for a more accepting attitude toward such affects by the patient. The therapist’s tendency not to shame patients when they reveal emotions provides experiences of extinction of fear of being shamed. Their ability to acknowledge their own empathic failures and their willingness to repair them also allow for the building of trusting representations of others, again, by extinction of fear of rejection and the creation of more positive emotional associations between the expression of hurt and an open and benevolent receptivity from other. Using affirmative interventions, such as validation (Killingmo, 1995) or signs of appreciation and admiration, the therapist helps create new validating procedures. When therapists “survive” and work to repair the bond after their patients’ narcissistic rage (Ornstein, 2009), they facilitate extinction of fear of being dismissed and help build a more accepting attitude toward hurt and anger.

Nondeclarative Effects of Declarative Interventions

NPD patients have been found to present low levels of metacognition (Dimaggio et al., 2007; Nicolò, Carcione, Semerari, & Dimaggio, 2007). In our opinion, the lack of self-awareness and reflective functioning observed in NPD patients rests on affect intolerance. This nondeclarative foundation of self-awareness explains why self-knowledge is so difficult to bring about: Affects are terrifying (the affect phobia and unmentalized nature of emotional memory) and subjected to active internal self-denigrating attacks (“I’m so stupid for being so weak”). In addition to their contribution to self-awareness, interventions aiming at improving the identification, labeling, and understanding of affective states have also a mentalizing impact through nondeclarative mechanisms. The nondeclarative ingredients of verbal interventions are especially consequential in early phases of treatment. For example,

a therapist observing that a patient must have felt hurt by his boss's critical remark is doing many things in addition to transmitting declarative information about the patient's emotions: By focusing the patient's attention on feeling hurt, he is arousing this emotional state in him (thus creating an opportunity for exposure); he is not denigrating the vulnerable affect (extinction of fear of being ridiculed); quite the contrary, he is showing interest in his feeling hurt (modeling an accepting attitude towards negative emotions); and he is normalizing and validating the emotion (gratifying a previously thwarted self-need, thus reducing hurt and the need for avoiding pain). All these nonverbal components of verbal interventions combine to create new non-declarative structures, more tolerant of shame-related affects.

Impact of Declarative Mechanisms on Nondeclarative Structures

The communication of symbolic contents about affects builds declarative structures in many ways. Using the last example, we see that by singling out shame, the therapist is contributing to its differentiation from other negative affects; he is suggesting a causal model for shame, such as being the result of a critical comment; this causal model reduces anxiety about shame by making it predictable; he contributes to a more coherent and complex view of self ("I tend to feel humiliated by critical remarks"); he is implicitly suggesting that the patient has experienced an emotion, that is, "only an emotion" and not an actual humiliating attack (not the reliving of the original traumatic shameful abuse, thus permitting an "as-if," symbolic stance toward emotions and increased metacognition); this symbolized emotion can serve as a signal to the self (Krystal, 1988). All these verbal-symbolic components of verbal interventions conjoin to form a larger, more complex, and differentiated declarative network, which becomes increasingly apt at inhibiting nondeclarative structures and putting symbolic structures to the fore of mental life, thus reducing automaticity in favor of more deliberate and self-serving goals.

CONCLUSION: RELATIONSHIP TO KOHUT'S AND KERNBERG'S APPROACH

We have argued that affect dysregulation in NPD patients rests essentially on unmentalized nondeclarative structures. We have proposed principally non-declarative therapeutic solutions to the reduction of grandiosity and arrogance: furthering affect tolerance through exposure and extinction and the creation of new intra- and interpersonal, more accepting, procedures. Verbal interventions also create nondeclarative structures by their interactive or relational impact. The symbolic content of interventions, while building declarative networks,

cannot directly modify or create nondeclarative structures. However, it can potentiate the creation of nondeclarative structures by momentarily inhibiting unfavorable nondeclarative procedures. As we see it, the nondeclarative processes and structures are modified, even though not always explicitly in terms of theory of technique, by all successful therapeutic approaches to NPD.

Kohut's approach to the treatment of NPD, as we understand it, is in tune with the nondeclarative emphasis of our argument. The process he called *transmuting internalization* (Kohut, 1984) is conceivably what we have referred to as the construction of nondeclarative structures through interpersonal (or intersubjective) transactions. Kernberg's (1984) therapeutic model of NPD, on the other hand, proposes the systematic interpretation of the grandiose self, which amounts to a treatment strategy principally based on declarative mechanisms. Thus, on paper, this approach seems to minimize the contribution of nondeclarative factors in the curative impact of psychotherapy. Now, in practice, the many years needed for the exploration of the defensive function of the grandiose self give many occasions for the "silent" exposure to and extinction of shame and the "internalization" by the patient of a more benevolent attitude toward his self and, thus, a strengthening of affect tolerance. This first "working through" part of the treatment is, in our opinion, at least as much a learning of new nondeclarative ways of being with self and others as an enterprise in "knowing" what grandiosity is about.

One might wonder: If every therapist eventually influences nondeclarative structures, sometimes even without being aware of it, why insist on their importance in the treatment of NPD? Because we feel these nondeclarative structures are at the heart of NPD patients' character organization. **Their nondeclarative nature is precisely what makes them so resistant to change.** Clearly, we are not submitting yet another "brand" of psychotherapy for NPD. Rather, we underline factors that we think are determinative in any successful treatment of NPD, whatever its theoretical persuasion. We hope we have made the reader more aware of the importance of taking into account the nature of nondeclarative structures and mechanisms. We also hope we have shown how clinicians can optimize the impact of their interventions for the modification of the unmentalized components of grandiosity and arrogance in patients with NPD.

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9

CONFLICTS AND DEFENSES IN NARCISSISTIC PERSONALITY DISORDER

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There is a rich tradition in the psychodynamic literature surrounding the origins, characterologic dynamics, and psychodynamic treatment of narcissistic personality disorder (NPD) that includes but transcends simple description (see Perry & Perry, 1996). This chapter focuses on two cornerstones of the psychoanalytic perspective on character: conflict and defense. We begin with a review of some of the relevant theoretical and empirical literature concerning conflicts and defenses associated with NPD. We end the chapter with a clinical case that demonstrates the moment-to-moment interplay of these conflicts and related defenses in a selection from a dynamic psychotherapy session. Together, these materials should enable the reader to understand the relevance of conflicts and defenses from the theoretical level down through empirical findings, ending with a demonstration of how they operate together in real life.

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CONFLICTS IN NPD

From the earliest psychoanalytic writing about defenses and unacceptable ideas (Freud 1894/1962), psychoanalytic psychology has posited that conflict plays a central role in psychopathology. At a fundamental level, individuals have a continuous task of expressing their motives (wishes and fears) in a way that adapts to both the internal and external environments. Originally, intrapsychic conflict was viewed as arising when circumstances trigger incompatible motives originating from different psychic structures (e.g., id, ego, superego). For instance, a salient wish, conflicting with a strict prohibition of the wish, results in a sense of threat (i.e., signal anxiety), which the ego then responds to with defensive actions (Freud, 1826/1959). The ego keeps the conflict out of awareness, thereby reducing the sense of threat, while temporarily allowing partial expression of some motives while denying others. The result leads to either symptom formation or compromise formations. Over time the concept of intrapsychic conflict has been broadened to include ideas that certain conflicts are specific to phases of development or that certain motives and defenses are associated with specific object representations that, in turn, affect the individual's interpersonal relationship patterns. As conflict is internal and partly or wholly unconscious, in the end, we can only infer conflict indirectly through what can be observed as anomalies or disturbances. From a measurement perspective, we consider a psychodynamic conflict as a pattern of motives, attitudes, beliefs, and other cognitions, characteristic interpersonal behaviors, object representations, and ways of handling affects that predispose the individual to having difficulty coping with certain stressors. The conflict, developed over time and embedded in the individual's personality, gives a particular pathogenic meaning to certain internal and external life stressors. In this view, stressful life events do not directly lead to the development of symptoms; rather, particular life events have a stressful meaning in part because the conflict gives it that meaning. Together, stressor and conflict function somewhat like a lock and key, which, mediated by defense mechanisms, lead to the onset of a symptom pattern, such as depression, anxiety, or impulsive behavior, or to attempts to avoid awareness of something related to the conflict. This view has evolved from ego psychology, but it also incorporates aspects of object relational and self psychology. This section summarizes findings about specific conflicts associated with NPD and narcissistic pathology.

The following findings were gathered from two studies, both using the Psychodynamic Conflict Rating Scales (PCRS; Perry, 2006). The PCRS assess 14 conflicts, along with 14 companion scales that reflect healthy adaptation to each conflict (Perry, 1990, 1997, 2006; Perry & Cooper, 1986). Each conflict reflects the scores of a series of 8 to 15 items, which are low-

inferential statements of some affective, behavioral, or cognitive facets of the conflict. There are seven focal and seven global scales, roughly synonymous with pre-oedipal and oedipal level conflicts.

The first study consisted of 55 individuals taken from a larger ($N = 124$) naturalistic study of individuals with borderline, schizotypal, and antisocial personality disorders compared with bipolar type II affective disorder. NPD was not one of the disorders in the inclusion criteria for the study, with the result that every person with NPD had at least one other study diagnosis. Diagnostic scoring of NPD was made directly in the intake Guided Clinical Interview for the second phase of subject collection ($n = 33$), but by rating videotaped dynamic interviews of individuals gathered in the first phase ($n = 92$; NPD diagnosis $k_w = .47$; NPD continuous score $I_R = .56$). Diagnoses and ratings of conflict were made independently and blinded to one another by different, experienced, clinician raters; for interrater reliability of an early version of the PCRS, mean intraclass $R = .59$ for conflict pattern identification (Perry & Cooper, 1986) and $.61$ intraclass R for the 14 continuous pathological scales (Perry & Perry, 2004).

The second study also consisted of 55 individuals taken from a larger ($N = 226$) naturalistic study of individuals entering residential treatment at the Austen Riggs Center (Stockbridge, Massachusetts) for treatment of refractory disorders. In the whole study group, 17 (8%) had NPD and 41 (18%) had significant narcissistic traits. Resources allowed only 55 to be rated.

In a report comparing both studies (Perry, 2009), the following six conflicts were found to be associated with the degree of narcissistic features in one or both samples. Each conflict is described below in descending order of the magnitude of the association.

- *Rejection of others*, perhaps the most central conflict in NPD, reflects disturbances in the regulation of self-esteem and affect and the experience of the self. Individuals with this conflict have an underlying view of themselves as small, powerless, unworthy of others' attention, and unimportant. This self-image is generally a repetition from childhood of how the individual experienced others' views of him or her. As adults, these individuals go to great pains to avoid experiencing or exposing this view of themselves to others. To avoid this, they continually make rejecting comments about others. At other times they may be aware of the negative view of themselves, which leaves them with a sense of vulnerability. Thus, this conflict is common to individuals with both the grandiose and vulnerable manifestations of NPD (Perry, 2009).

One result of these individuals' underlying negative view of themselves is that they are unable to regulate or to have lasting

good feelings about themselves (Kernberg, 1970). The following dynamic operates out of each 'individual's awareness. The individuals continually look to others to foster the belief that they should be seen in a positive light because of alleged positive, praiseworthy qualities. If others see them in this way (or if they believe that they do), then they temporarily feel adequate, deserving, and good. Because these good feelings are only reactive, however, they wear off quickly, leaving the individuals to feel uneasy again. As negative feelings about themselves return closer to consciousness, the individuals reengage in defensive maneuvers. They commonly use defenses to promote a sense of power (i.e., omnipotence), overvalue aspects of themselves (e.g., idealizing exaggerating positive qualities), or idealize certain others as if their positive attributes apply to themselves by association. Conversely, these individuals may devalue themselves or others whenever this negative self-view reaches awareness. The devaluation is global in nature, and the individuals take one fault or shortcoming as evidence that they or someone else is entirely failing or worthless.

- *Resentment of being thwarted by others* is a conflict in which individuals believe that others have no right to impose limits, controls, or sanctions to keep them from doing whatever they want. Rather, they believe that they should be able to do whatever they want, whenever they want. They resent others' imposition of rules or expectations as unwarranted interference, regardless of any rules, laws, or duties that they might otherwise agree should generally be followed. Because this is ego-syntonic, these individuals may not be aware of this resentment. Moreover, they may overtly ascribe to the very expectations, duties, and rules that they covertly resent and resist. The exception is rationalized.

Resentment may show in active-direct or passive-indirect ways. When direct, individuals may complain about and openly transgress any sanctions encountered. Although such transgressions might be impulsive or deliberate, they would be imbued with an angry quality, as in seeking revenge. When indirect, individuals rationalize their complaints to cover up a hypocritical position regarding any sense of duty. Resistance then appears defensible, as a response to injustice, rather than self-centered and based on resentment. They then find innumerable ways to resist demands and evade agreed-upon duties or moral obligations.

- *Counter-dependent conflict* characterizes individuals with a fierce need to maintain independence from others. They continually strive to declare their independence through disavowal of their own dependency needs or those of others. They may reject others' attempts to provide material or emotional support to them in order to maintain a facade of self-sufficiency and strength. Their vulnerabilities lie chiefly in fears of loss of control and autonomy at times when feelings of dependency or affection arise toward another. They eschew nurturing or largesse that others may offer because of the fear of experiencing dependent longings. Such individuals may instead gravitate toward taking care of others' needs, thereby appearing strong. An example of this is the patient with a narcissistic and paranoid personality disorder who entered each therapy session only after handing payment to the therapist, accompanied by a supercilious smile.
- *Dominant goal* is found in individuals who derive their self-esteem largely from seeking to achieve certain goals that override all else in life. They often shun other forms of satisfaction in the single-minded belief that obtaining their chosen goals will result in being valued and treated by others as highly special, in ways reminiscent of childhood praise (Kohut, 1966; Kohut & Wolf, 1978). Fantasies and wishes surrounding the particular dominant goal are used to eschew other sources of satisfaction and meaning in life. The dominant goal conflict leaves these individuals very vulnerable to failure, setback, or other threats to meeting the dominant goal. They are also somewhat insensitive to the emotional support that might otherwise cushion them whenever such disappointments occur. This conflict was described by Arieti and Bemporad (1980) as one of three that predispose individuals to depression. In the Nobel Prize complex, Tartakoff (1966) described a narcissistic variant of dominant goal in which the individual has omnipotent fantasies of power and being special. Goal frustrations and failures can lead to psychological devastation and even suicide because self-esteem and self-image are almost entirely dependent on perceived success (Sperber, 1972).
- *Ambition-achievement*, like dominant goal, characterizes individuals who view themselves as having special personal attributes, such as special talents, abilities, destiny, or goals, and have an intense desire to live up to the expectations of others for their success. Individuals with this type of conflict

want the positive feelings that ensue whenever others praise, admire, or otherwise distinguish them for these special attributes or accomplishments. On the other hand, not living up to expectations results in an intense sense of shame and a vulnerability to criticism for disappointing others and oneself. In conflict with this wish to achieve specialness through achievement is that these individuals lack the requisite ambition or real talent or ability to achieve these goals. In childhood, praise may have been directed toward superficial qualities or accompanied partial accomplishments (Kohut & Wolf, 1978), regardless of actual results. This results in some ambivalence about the work necessary to achieve. As a result, these individuals often prefer to plan or fantasize about what they might accomplish to retain special status, rather than actually commit to doing it. Being seen to have the potential for achievement (i.e. making great plans) may paradoxically be preferred to actually striving for achievement. Alternatively, once committed to action, they may self-sabotage, ensuring failure in a way that they can rationalize as accidental. Individuals may derive feeling special for appearing promising regarding future accomplishments, rather than for actual accomplishments in the present.

- *Object hunger* is found in individuals who have an intense need for people to fill an emotional void affecting their sense of continuity of the self. This emotional void leaves them with the feeling that their emotional stability is endangered unless they have an attachment to some person on a day-to-day, hour-to-hour basis; without such an attachment, they have a hunger for attention. This need for attachment is not specific to any one individual or relationship. The individuals may be indiscriminate in their choice of persons to whom they attach. Simply having someone there gratifies the need for another person. The individuals seem grateful for the other's presence and seem to get a sense of stability, meaning, and even identity by the connection, even when that connection is very transient. These individuals may interact in self-centered or promiscuous ways, like Mozart's Don Giovanni. This conflict mirrors the philosopher Berkeley's precept *Esse est percipi* (To be is to be perceived). These individuals seek out others a fair amount of the time in day-to-day as well as social activities. Although they may have some lasting attachments, they also traverse easily from one to another without distress that some attachments are short-lived. The capacity to be alone is very diminished.

Most individuals with NPD have one or more of the conflicts described in degrees varying with their upbringing. Whereas gross childhood traumas, such as physical and emotional abuse, were often absent, there was an accumulation of frequent, even daily, experiences of feeling overvalued, undervalued, or devalued. This resulted in durable disturbances of the self and self-esteem regulation. Kohut and Wolf (1978) described both excessive gratifying and depriving experiences as predominant, whereas Kernberg (1970, 1984) has emphasized the role of severe frustration in the development of pathological internal representations of self and others. As yet, we do not have a systematic empirical understanding of the relationships between factors in the genesis of NPD and associated specific conflicts and defenses. As this becomes available, it should improve our understanding of the pathology and inform our treatment approaches.

DEFENSE MECHANISMS

Whereas the common view is that defenses are usually pathological, their aim is in fact to facilitate adaptation to internal and external stressors and conflict. Research has recurrently found that defenses can be arranged hierarchically as to their general level of adaptiveness. One aspect of character or personality disorder is that individuals tend to rely on specific defenses that often share functions and cluster in certain parts of the hierarchy. Personality disorders rely excessively on so-called immature defenses in the lower half of the hierarchy, but different types of personality disorders have differential preferences for individual defenses (Perry & Bond, 2005).

In his seminal paper, Kernberg (1967) described most patients with NPD as falling within a broad borderline personality organization (BPO), inclusive of other Cluster B personality disorders. He posited that any disorder within BPO is associated with splitting, idealization, projection, devaluation, denial, and grandiosity-omnipotence (Kernberg, 1967). However, this has led to confusion in the personality disorder literature regarding how personality disorders, particularly those within Cluster B, can be differentiated based on defense mechanisms (Presniak et al., 2010). In this section of the chapter, we delineate those defenses characteristic of NPD, indicating how defenses help differentiate NPD from other borderline conditions.

Splitting

Kernberg (1967, 1974, 1984) posited that splitting is the predominant defense mechanism of any disorder falling within BPO. Patients with such conditions show an incapacity to synthesize both positive and negative images

of the self and others. Clinically, this is most commonly manifested through alternating between the expression of sides of a conflict, such as the “all good” and “all bad” description of self or others, while denying the complementary side. Although NPD falls within BPO, Kernberg (1974) explained that splitting in NPD manifests itself slightly differently than in other disorders. In NPD, splitting is reflected through the split-off self-states of grandiosity, shyness, and feelings of inferiority that may coexist. However, the latter state is defended through repression and the inflated grandiose state. Therefore, unlike patients with a diagnosis of borderline personality disorder who tend to demonstrate splitting through the vacillation of good and bad images of others and self, patients with NPD tend not to show this vacillation because their split images are defended effectively. It is only through a “narcissistic injury” or during psychotherapy that the devalued self rises into awareness (Gacono, Meloy, & Berg, 1992; Kernberg, 1970). Therefore, splitting is much more difficult to see in patients with NPD, which may explain why the empirical support for splitting in NPD has been weak.

Four studies have examined the association of splitting to NPD, with only one showing a significant positive relationship (Blais et al., 1999; Clemence et al., 2009; Lingardi et al., 1999; Perry & Perry, 2004). To complicate matters further, one study found a negative correlation between splitting and NPD (Blais et al., 1999). Three studies have compared the use of splitting in NPD compared with other personality disorders, and none found splitting used more in the NPD group (Berg, 1990; Gacono et al., 1992; Hilsenroth, Hibbard, Nash, & Handler, 1993). Paradoxically, these studies may be consistent with Kernberg’s assertion that splitting functions slightly differently in NPD compared with how clinicians typically view the defense (i.e., alternating between “all good” and “all bad” images of others). In fact, the report (Clemence et al., 2009) that associated splitting (of others’ images only) with NPD studied residential group patients with treatment-refractory disorders who likely experienced narcissistic injuries.

Omnipotence/Grandiosity

The most characteristic defense of NPD patients is their use of omnipotence or grandiosity. Although these two terms have been used synonymously at times, their definitions vary slightly. *Grandiosity* refers to a self-representation (the grandiose self) with attribution of exaggerated positive qualities to the self, wherein the self is seen as superior in comparison with others (MacGregor, Olson, Presniak, & Davidson, 2008). *Omnipotence* refers more specifically to the defense mechanism in which one “acts superior,” as though one possesses special powers or abilities (Perry, 1990). Both of these are considered prominent features of NPD. One interesting differentiation between the two

patient groups is this: Unlike patients with borderline personality disorder, who have no integrated self-concept, patients with NPD have a highly integrated self-concept. Although pathological in nature, they have a grandiose self-view, which is composed of an amalgamation of aspects of their "real self" (e.g., their specialness as a child that was reinforced), "ideal self" (e.g., self-image as powerful and beautiful), and "ideal object" (e.g., fantasized ever-loving and accepting other; Kernberg, 1970). Thus, individuals with NPD identify with their own ideal self-image and merge this altered view of themselves with how they perceive that others see them. In NPD, the integrated grandiose self-view functions to maintain their relative good functioning, despite the use of lower level defenses or poor object representations or interpersonal relationships.

Two studies have shown that the defense omnipotence is positively associated with NPD (Clemence et al., 2009; Perry & Perry, 2004). However, when NPD is compared to other personality disorders, the results have been mixed. One study found grandiosity to be more prominent in an NPD group (Berg, 1990), but two studies did not replicate this finding (Gacono et al., 1992; Hilsenroth et al., 1993). Overall, it is necessary to clarify measurement issues relating to grandiosity and omnipotence to improve further research on their association to NPD.

Devaluation and Idealization

The use of additional minor image-distorting defenses allows NPD individuals to enhance their self-esteem even further, whenever they are confronted with potential failures or they experience an attack on their self-image (Clemence et al., 2009). The use of devaluation and idealization helps to maintain their grandiose self-view. Devaluation involves attributing exaggerated negative qualities to another object, which allows the NPD individual to dismiss the other as inferior or to dismiss a disappointment as of little import. For individuals with borderline personality disorder, the negative view of others tends to exacerbate feelings of dysphoria and view of the self as damaged (Gacono et al., 1992; Presniak et al., 2010); by contrast, for individuals with NPD, devaluation tends to enhance a grandiose self-view. Others are seen as inferior, which also maintains NPD individuals' interpersonal detachment. Images of others tend to be destructed to such a degree that the internal representations are insubstantial, and although there are some characteristics of real people, they tend to be "lifeless, shadowy people" (Kernberg, 1970, p. 57). In NPD, people are generally divided into those that are special and powerful versus those who are mediocre or diminished. NPD individuals tend to use devaluation of those in the latter category when stress engages their own fear of being ordinary or mediocre.

Narcissistic individuals idealize those who are special, rich, and powerful, which, as Kernberg posited, typically stems from feelings of envy (Kernberg, 1967; Perry & Perry, 2004). However, these objects tend only to be idealized when they are seen as representatives of the self and as objects from which they can gain some value. These relationships tend to be exploitative because NPD individuals feel they have the right to control and possess others and use them to make their own personal gains (Kernberg, 1967). Although the relationships can sometimes appear dependent on others, with closer inspection, it is evident that the NPD individuals are not dependent but instead use the relationships to receive a large amount of adoration. Underneath their exterior, they both distrust and devalue most others. In particular, once a person's value has been acquired, NPD individuals tend to see them as valueless and toss them aside (i.e., they become devalued objects). This is often evident in the therapeutic relationship in which the therapist is initially very strongly idealized, yet, underlying this idealized view, the NPD patient experiences a strong distrust of the therapist. By contrast, Kohut and Wolf (1978) posited that idealization is a reparative process shoring up a weak sense of self, borrowing on the strength of others.

The empirical evidence for idealization and devaluation has been mixed. Three studies have examined the association of these defenses to NPD; two found an association between devaluation and NPD (Clemence et al., 2009; Perry & Perry, 2004), one found an association between idealization and NPD (Clemence et al., 2009), and one found no associations (Blais et al., 1999). Two studies have compared these defenses between personality groups (Gacono et al., 1992; Hilsenroth et al., 1993). Neither found that the NPD group had higher scores on devaluation, whereas both showed higher scores on idealization.

Additional Defenses

The most characteristic defense of NPD is use of omnipotence in support of the grandiose self-view. However, this grandiose self is maintained only through the use of other defenses that disavow their inner experiences and allow them to distort the images of both self and others. Of primary importance is that in NPD their negative self-images (the contradictory splitting state of the self) are repressed and tend to be projected onto other objects (Kernberg, 1970). This sometimes results in a generalized paranoid orientation characterized by distrust and devaluation of others. The association of NPD with projection is generally accepted in the literature (Kernberg, 1970) and is supported by findings from two studies (Clemence et al., 2009; Perry & Perry, 2004). The use of repression has been debated. Some have argued that NPD individuals do not use repression because they have fewer

(or even no) unconscious conflicts compared with other patients (Kohut & Wolf, 1978). By contrast, Kernberg (1970) suggested that NPD individuals are often quite successful at repressing material, particularly their negative self-images (Kernberg, 1970). Another possibility is that their ability to keep these aspects of their personality or self-image out of awareness is through their ability to split their self-images and consequently deny the negative self-views. Gacono et al. (1992) described this mechanism as quite characteristic of antisocial personality disorder, but it easily could also be characteristic of NPD. In its most primitive form, any negative images or potential attacks on their grandiose self-image are denied and therefore kept out of consciousness, and in its more advanced level, rationalization is used whereby evidence of any negative self-image or exploitative acts are explained away (Gacono et al., 1992). Regardless of whether repression, denial, or both defenses are used, there is agreement in the literature that for NPD patients to maintain their grandiose self-view, the negative aspects of their self-image are kept out of awareness. Together, the defenses of denial, rationalization, and projection protect self-esteem by disavowing any internal experiences of problems through either denying the problem, covering it up or justifying their responses, or misattributing their experiences to others (Clemence et al., 2009; Millon, 1986; Perry & Perry, 2004).

Very few studies have examined these defenses in NPD, particularly because most studies have used the Rorschach-based Lerner Defense Scales (Lerner, Albert, & Walsh, 1987), which do not assess these four defenses except for denial. Three studies have examined repression, two of which reported a negative association to NPD (Clemence et al., 2009; Perry & Perry, 2004). Four studies have examined denial, of which one found a positive association to NPD (Cramer, 1999). Four studies have examined projection, three of which found a positive association (Clemence et al., 2009; Cramer, 1999; Perry & Perry, 2004). Three studies have examined rationalization, one of which found a positive association (Clemence et al., 2009). Only one study has compared mean differences on any of these defenses between NPD and other personality disorders (Hilsenroth et al., 1993). The authors found that the NPD group did not score higher on denial compared with groups with borderline personality disorder or Cluster C personality disorders. No other defense was assessed.

Discussion

Although there are a larger number of defenses that are used by individuals with NPD, we have described the most characteristic defenses. Individuals with NPD have split off their negative self-images from those that are positive, allowing the grandiose self-image into awareness. Although the

defense splitting may not be evident until a narcissistic injury occurs, they tend to idealize those that they envy (those that are rich and powerful) and devalue all others. However, when presented with severe failure they may also devalue themselves. These two defenses typically stem from their own fears of inferiority, which they then project onto others. Additionally, they tend to deny or rationalize any experiences that may be perceived as tarnishing or attacking their grandiose self-image. Although these defenses protect self-esteem, they also contribute to poor interpersonal relationships. Presently, the research support for these defenses is modest, partly because of the sparse number of studies focusing on NPD as well as to measurement differences. Only one study specifically focused on defenses in NPD (Perry & Perry, 2004). Although additional studies have included NPD in their samples, sample sizes of patients who met diagnostic criteria for NPD were very small, often less than 15 (Blais et al., 1999; Clemence et al., 2009). Based on our own experience, this is partly because individuals with NPD typically eschew participation in research. Nonetheless, additional and more comprehensive research on defenses is strongly needed with larger NPD samples.

CASE EXAMPLE

The following case demonstrates the interplay of defenses and conflicts at the moment-to-moment level. (The patient's identity has been disguised to maintain confidentiality.) Mr. F. was a man in his mid-20s who was referred to therapy after the end of his relationship with a girlfriend. He felt he was "a basket case." Following a history of abuse, then dependence on cannabis beginning at age 13, he had been abstinent for over a year. He had no other Axis I disorders, except a history of childhood conduct disorder. On Axis II, he had histrionic and narcissistic personality disorders, with significant anti-social, self-defeating, and borderline traits.

The patient felt loved by his parents in his early years, although his mother was strict, not showing her emotions readily, but unconditionally loving and understanding. He lost an eye at age 5 because of illness and remembered the event as suffused with caring. Grammar school went well; there were no academic problems, and he had friends. The parents argued a lot, and the father was physically abusive to an older brother, who in turn from mid-childhood onward became verbally and physically abusive to the patient. The children could tell that their parents were heading for divorce. While Mr. F. was at summer camp at age 12, his mother was hospitalized, allegedly for anorexia; in fact, she had made a suicide attempt. After discharge, she went to live with relatives. After the divorce, the children lived with their father. He was preoccupied with a new girlfriend and exercised no oversight.

population creates gaps in our knowledge concerning etiology, economic costs, planning of mental health services, and treatment.

Most of the research on NPD comorbidity has been conducted in clinical samples (George, Miklowitz, Richards, Simoneau, & Taylor, 2003; Mantere et al., 2006; Oldham et al., 1995; Ronningstam, 1996; Skodol et al., 1995; Skodol, Oldham & Gallaher, 1999; Skodol, Stout, et al., 1999; Zimmerman, Rothschild, & Chelminski, 2005). In most of the clinical studies, no significant associations were found between NPD and most mood and anxiety disorders, with the possible exception of bipolar disorder. Evidence linking NPD with substance use disorders, though strong in earlier clinical work (Ronningstam, 1996), remains mixed when more recent clinical studies are considered (Fossati et al., 2000; Skodol, Oldham, et al., 1999). By contrast, NPD has consistently been shown to be associated with histrionic, antisocial, obsessive-compulsive, and schizotypal personality disorders (Fossati et al., 2000; Marinangeli et al., 2000; Stuart et al., 1998), with mixed evidence for a relationship with borderline personality disorder (Grilo, Sanislow, & McGlashan, 2002; Marinangeli et al., 2000; Stuart et al., 1998; Zanarini et al., 1998).

Relative to clinical work on NPD, very little is known about disability and comorbidity of NPD in general population samples. Although prevalence estimates of NPD are available from several early community surveys (Black, Noyes, Pföhl, Goldstein, & Blum, 1993; Ekselius, Tillfors, Furmark, & Fredrikson, 2001; Klein et al., 1995; Lenzenweger, Loranger, Korfine, & Neff, 1997; Maier, Lichtermann, Minges, & Heun, 1992; Moldin, Rice, Erlenmeyer-Kimling, & Squires-Wheeler, 1994; Reich, Yates, & Nduaguba, 1989; Zimmerman & Coryell, 1989), these surveys were geographically restricted, in addition to being limited by small sample sizes ($N_s = 229-797$). Others (Coid, Yang, Tyrer, Roberts, & Ullrich, 2006; Lenzenweger, Lane, Loranger, & Kessler, 2007; Samuels, Nestadt, Romanoski, Folstein, & McHugh, 1994) used statistical techniques to impute prevalence rates of NPD from small subsamples of individuals to larger general population samples, further limiting the precision of prevalence estimates.

Only one large epidemiologic survey (Torgersen, Kringlen, & Cramer, 2001) conducted in Oslo, Norway, yielded prevalence estimates of basic sociodemographic factors of NPD, reporting 0.8% prevalence of NPD in their sample. Two more recent studies (Pulay, Goldstein, & Grant, 2011; Stinson et al., 2008) using the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC; Grant, Kaplan, & Stinson, 2005) reported data on the prevalence, correlates, and comorbidity of NPD across sociodemographic characteristics and found a substantially larger rate of NPD (6.2%) in the U.S. general population. Stinson et al. (2008) reported high co-occurrence rates of NPD with substance use, mood, anxiety, and other personality disorders and found independent associations between NPD and

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COUNTERTRANSFERENCE ISSUES IN THE TREATMENT OF PATHOLOGICAL NARCISSISM

GLEN O. GABBARD

In contemporary discourse among psychotherapists and psychoanalysts, the term *narcissistic* is often used as an insult. One may use the term to refer to colleagues who are self-confident or who seem to think more about themselves than others. The implication of the label is that the colleague who is self-absorbed and insensitive to the needs of others presents a challenge to others. Specifically, this individual may seem so “toxic” that others may prefer to spend their time in the company of someone else. Patients with pathological narcissism may be experienced similarly by clinicians because they often produce characteristic feelings in those around them that are recreated in the therapeutic setting. Indeed, the success of the treatment may rest on the therapist’s capacity to tolerate the countertransference reactions that are evoked by narcissistic patients and to forge a therapeutic alliance (the most potent predictor of outcome in psychotherapy) despite those feelings. One might even say that the therapist is facing the core difficulty of narcissistic

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patients: How can they improve their capacity to develop gratifying relationships with others when so many people are alienated by their interpersonal style? Hence, a discussion of what is transpiring in the consulting room between therapist and patient often leads to the heart of their problems outside the therapeutic setting.

Countertransference today is regarded as intimately and inextricably related to transference (Gabbard, 1995). Although the construct was classically regarded as the analyst's transference to the patient (i.e., feelings that stemmed from the analyst's past relationships displaced onto the patient), today most psychoanalytically oriented clinicians would agree that countertransference is jointly created by the patient and the therapist. In other words, the patient's transference to the therapist induces a set of feelings in the therapist that are in turn influenced by the preexisting internal object relations of the therapist. Some induced feelings are a better "fit" than others.

Transference and countertransference are best conceptualized as the unconscious recreation of the patient's internal object world in the relationship with the psychotherapist. Indeed, the character dimension of personality is usefully conceptualized as involving an ongoing attempt to actualize certain patterns of relatedness that are ubiquitous in the patient's life (Gabbard, 2005a). Through interpersonal pressure in the here-and-now of the clinical setting, narcissistic patients try to impose on the therapist a particular way of responding and experiencing. What are called character traits, then, can be viewed as the attempt to actualize a wish-fulfilling internal object relationship that is firmly entrenched in the patient's unconscious (Sandler 1981). A patient may wish to be admired by the therapist and therefore boast about his many accomplishments to elicit an admiring response. The method, however, may backfire; the therapist may become increasingly irritated and alienated by the patient's boasting. Hence, the tragedy of patients with pathological narcissism is that they are unable to elicit the responses from others that will stabilize their self-esteem that they so desperately long for.

The mode of actualization within the analytic relationship is often referred to as *projective identification* (Gabbard, 1995; Ogden, 1979). Stemming from the thinking of Klein (1946/1975) and Bion (1962), this model involves the notion that patients tend to behave in a characterologically driven way that leads them to "imagine" the therapist into assuming a role that originates within the patient. In other words, by behaving in a particular way, the patient influences the therapist to take on characteristics of an internal object representation or representation of the self. A narcissistic patient who makes contemptuous comments about the therapist may eventually trigger in the therapist feelings of anger or hatred.

The repetitive relationships established in the transference and countertransference of the clinical setting may approximate real relationships in the

patient's past. However, relationships based in fantasy may also be part of a patient's internal world. Transference longings often reflect intensely wished-for relationships that never really materialized in the patient's childhood. Children who grow up with neglect and abuse may long for an idealized rescuer who will save them from abuse, and they may approach others with that wish activated in a variety of different settings.

EMPIRICAL DATA

Most of our knowledge about narcissistic personality disorder has emerged from psychoanalysis and intensive psychoanalytic psychotherapy. We have little research to provide a systematic understanding of transference and countertransference phenomena in large series of patients with the diagnosis. Recently, a growing body of empirical data has helped illuminate those characterological features that are hallmarks of narcissistic personality disorder.

Betan et al. (2005) studied countertransference processes in clinical practice and related it to personality pathology. A randomly selected national sample for this study consisted of 181 clinical psychologists and psychiatrists in North America, and each of these clinicians completed a battery of instruments on a patient in their care. Included among these instruments was the Countertransference Questionnaire (Zittel & Westen, 2003). When the responses to the Countertransference Questionnaire underwent factor analysis, an aggregated portrait of countertransference responses to patients with narcissistic personality disorder provided an empirically based description that strongly resembled clinical and theoretical accounts. Clinicians reported feeling resentment, anger, and dread when treating such patients. They also found themselves behaving in avoidant or distracted ways and harboring wishes to terminate the treatment. In addition, they described feeling criticized and devalued by the patient. These feelings were independent of the therapist's theoretical preferences.

These typical countertransferences are obviously responsive to a set of characterological features that typify narcissistic personality disorder. These traits are the source of characteristic interpersonal problems. Ogrodniczuk et al. (2009) studied 240 consecutively admitted patients to a day treatment program. These patients completed measures of narcissism, interpersonal problems, and general psychiatric distress. Those individuals that were characterized as "highly narcissistic" had several features in common: They were domineering, vindictive, and prone to intrusive behavior. The domineering behavior was composed of controlling and aggressive features that reflected an inability to empathize with others. The vindictive behavior was characterized by vengeful and suspicious features, suggesting an incapacity to enjoy

another person's happiness or to be supportive of another's goals in life. The intrusive behavior was composed of exhibitionistic features and reflected an inability to keep things private and to respect the personal boundaries of others. The investigators also found that a failure to complete treatment in the program was associated with high scores in narcissism.

The defining features of the narcissistic patients in the study can be viewed as accounting for the typical countertransference problems that were described in the study conducted by Betan et al. (2005). If we understand transference as involving the continuation in the treatment setting of habitual modes of object relatedness by the patient, then characteristic patterns of response occur in the clinician's countertransference. As discussed in Chapter 2 of this volume, narcissistic personality disorder is not a monolithic entity but a spectrum of subtypes (Gabbard, 2005b; Russ et al., 2008).

The research suggests that the principal subtypes share several key features: conceit, self-indulgence, and disregard for others. However, the vulnerability-sensitivity group is characterized as introverted, anxious, defensive, and vulnerable to life's traumas. By contrast, the grandiosity-exhibitionism group was extroverted, self-assured, aggressive, and exhibitionistic. Hence, one might say that a critically important distinction revolves around narcissistic vulnerability. The hypervigilant narcissist is exquisitely vulnerable to narcissistic wounding, whereas the oblivious narcissist is more intensely defended against that vulnerability.

COMMON PATTERNS OF COUNTERTRANSFERENCE

The empirical literature identifies prototypes—personality subtypes in ideal or pure form. In clinical work, one commonly finds patients who have characteristics of more than one subtype and who reside along the continuum between the oblivious or overt subtype and the hypervigilant or narcissistically vulnerable subtype. Hence, the transferences that develop are related to the constellation of features stemming from the various subtypes identified in the aforementioned research, as well as by idiosyncratic patterns of object relatedness that have been internalized in childhood. It is clinically useful to identify themes that occur in the psychotherapy or psychoanalysis of these patients that are relevant to specific countertransference challenges.

Therapist as Sounding Board

The oblivious narcissistic patient uses the therapist as a sounding board, a listening ear that exists primarily to enhance the patient's self-esteem. Such patients do not really "connect" with the therapist in the way that

neurotically organized patients do. They talk on and on about themselves in a self-aggrandizing way without studying the therapist's face to see what is happening in the therapist's internal world. This absence of mentalizing is connected with a lack of curiosity about the therapist. Indeed, the oblivious narcissist may induce a feeling in the therapist that "this patient has no transference." The astute clinician, however, knows that this apparent absence is in fact the transference (Brenner, 1982).

This apparent mode of nonrelatedness is the way that some narcissistic individuals relate to everyone. Kohut (1971) viewed this style of relating to the analyst as a version of the mirror transference, where the patient is hoping to receive confirming and validating responses from others as a way of shoring up a fragmented self and increasing his or her sense of self-esteem. Kohut referred to these as *selfobject transferences* because the other person is used as a missing part of the self. Hence in this form of narcissistic transference, the patient is not aware of the therapist's separate subjectivity and internal world; the therapist is only there to affirm the patient's self-worth.

Clinicians who practice psychotherapy tend to have a need to be needed (Gabbard, 2005b). Narcissistic patients deprive the therapist of fulfilling that need to a large extent. The oblivious subtype often is experienced as speaking "at" the therapist instead of "to" the therapist (Gabbard, 1998). Being used as a sounding board makes one feel isolated, what Kernberg (1970) referred to as a "satellite existence." Therapists feel that their independent center of autonomy, their unique subjectivity, their very "personhood" is not being acknowledged. The therapist may feel ineffectual, colorless, invisible, and deskilled. The common defensive response to this feeling of uselessness is to become bored and disengaged. The therapists may feel a sense of dread when the patient's session is due to begin, and they may count the minutes until the end of the session.

Steiner (2008) wrote about the transference to the analyst as an excluded observer. Indeed, in the presence of an oblivious and grandiose narcissistic patient, therapists may feel chronically excluded, as though they are consigned to the role of silent or approving observer whose insights are not welcome. Steiner stressed that this particular transference is conducive to countertransference enactments. Therapists may wish to force themselves back into the primary role with the patient or to take sides in an argument involving moral dilemmas. Hence, therapists may find themselves behaving in an overly assertive or judgmental manner that, on reflection, they recognize as being counterproductive. One of the paradoxes is that this sort of patient comes to therapy ostensibly to receive help, feedback, and observations from the therapist but then does not allow the therapist to do the job that he or she is being paid for.

Many of those who choose careers in psychotherapy harbor a wish to be loved and idealized (Finell, 1985); thus, there is potential for therapists to experience narcissistic wounding that parallels what the patient experiences.

Because the narcissistic patient tends to treat the therapist as a self-extension, the patient is likely to evoke certain states in the therapist that reflect the patient's own internal conflicts. It is also true, however, that patients may use projective identification to externalize an aspect of their self-experience into the therapist. Therefore, a therapist who is feeling excluded and bored may be experiencing what the patient went through as a child who was distanced or excluded by a parent. In other words, some narcissistic patients may attempt to master their childhood trauma by unconsciously recreating it in the therapeutic situation (Gabbard, 1998).

Contempt

Therapist feelings of being the object of contempt are unavoidable with narcissistic patients. Therapists must keep in mind that narcissistically organized individuals characteristically stabilize their self-esteem by devaluing others. We expect narcissistic patients to carry their usual defensive styles of object-relatedness into the treatment, so therapists must prepare themselves for being a devalued object much of the time. Betan et al. (2005) found that the hallmarks of countertransference to narcissistic patients were feelings of being devalued and criticized by the patient, accompanied by anger, resentment, and dread in working with such patients.

A variety of responses can result from feelings of being treated with contempt day in and day out. Some therapists may use reaction formation against their growing feelings of anger and hurt. They may become overly empathic and overly kind to the patient as a way of denying their true feelings. This stance may simply activate the patient's envy and rage to a greater extent, leading to a vicious cycle of greater contempt followed by greater reaction formation in the therapist. Patients may also feel that they are being ineffectual in trying to produce the desired response in the therapist.

Other therapists may react by becoming more aggressive and competitive with the patient. They may become so exasperated with being denigrated that they become defensive and demonstrate that they are more intelligent, well-read, worldly, and knowledgeable than the patient. Of course, this reaction only provides the patient with further ammunition to devalue the therapist as a hypersensitive and narcissistically vulnerable individual who has to "show off" his knowledge. Hence, these kinds of countertransference enactments allow patients to projectively disavow their own narcissistic vulnerability and see it only in the therapist.

As one attempts to tolerate the patient's contempt, it is useful to remember that the fundamental disturbances in narcissistically organized patients are feelings of inadequacy associated with difficulties in regulating their self-esteem. One common defensive strategy is to devalue others as a way of

making oneself feel superior and less inadequate. Patients who come for help may immediately feel in a one-down position with respect to the therapist and need to treat the therapist with contempt as a way of trying to level the playing field. The grandiose–malignant patient may engage in this contempt, but the fragile or hypervigilant narcissistic individual may also devalue the therapist, especially when feeling narcissistically wounded, ignored, or rejected by the therapist. A small change in the therapist's appearance may lead the patient to erupt in narcissistic rage. This rage may be accompanied by contemptuous and devaluing comments about the therapist's capacities.

Another useful strategy that helps therapists to tolerate the patient's contempt is to remember that it often is related to envy. Narcissistic patients are frequently envious of those who seem to have things that they do not. The therapeutic situation presents narcissistic patients with a dilemma: To receive help, they must acknowledge that the therapist knows something that they do not. This situation results in their feeling diminished in comparison with the therapist, who appears to have wisdom and knowledge. A common response to envy is to try to spoil and devalue what one cannot have, much like the "sour grapes" story in Aesop's Fables (Kernberg 1970, 1984). By insisting that the therapist is incompetent and does not really know anything useful, patients can convince themselves that there is nothing to envy and hence they do not need to feel inferior about themselves. A variation on this envy was noted in the findings of the day hospital study reported by Ogrodniczuk et al. (2009) when they characterized vindictive behavior as reflecting an inability to feel good about another person's happiness or to be supportive of another's goals in life. To do so would be to recognize envy of something good that someone else has.

Idealization

In addition to the mirror transference, Kohut (1971, 1977, 1984) also recognized other types of selfobject transferences in narcissistically organized individuals. To shore up shaky self-esteem and to achieve more cohesion of the self, some patients may idealize the therapist. They may perceive the therapist as an all-powerful parent whose presence soothes and heals. By basking in the reflected glory of an idealized therapist, they vicariously have a sense of self-esteem conferred upon them. Such patients may come to therapy just to be in the presence of a therapist and not really show any initiative to analyze or understand the problems that brought them to therapy. They may feel that being with a therapist is an end in itself—they have found the ideal person and do not need to look any further.

Being idealized may not enter the therapist's radar screen as a form of transference. Therapists who need to be idealized may experience the

* transference simply as an example of a patient who recognizes the therapist's talents and empathy or the reflection of a good therapeutic alliance. Thus, one reaction to being the object of idealization is to have a blind spot regarding the idealizing transference.

Other therapists may find being idealized to be acutely uncomfortable, as Kohut (1984) himself described. The experience of idealization may make therapists feel conflicted about the activation of their own grandiosity. Their secret or not-so-secret wish to be idealized is being gratified in a way that may make them feel grandiose or extraordinarily narcissistic. A common enactment is to prematurely interpret the idealization rather than recognize the patient's need for idealization as a way of regulating self-esteem.

Omnipotent Control

* One of the most common transferences, regardless of the narcissistic subtype, is an effort to control the therapist. Rosenfeld (1964) stressed that for a narcissistically organized person, the greatest concern is an experience of separateness between subject and object. Much of what transpires is an effort to prevent that separateness. This fantasy of controlling what the therapist does manifests in a variety of ways in the transference. Patients may use the therapist as an extension of the self and not allow the therapist any space to make comments from an outside perspective that might challenge the patient's experience of fusion. Hypervigilant or fragile narcissistic individuals may never take their eyes off the therapist, as though through intense scrutiny of the therapist's every move, they maintain the fantasy that the therapist is completely under their control. Erupting in narcissistic rage when the therapist does not conform to the patient's expectations also may be related to a fantasy that bullying and intimidating the therapist with anger will enable them to subjugate him or her.

Symington (1990) once noted that projective identification can be construed as an attempt by the patient to control the therapist's freedom of thought. With narcissistic patients, therapists may feel subjugated by their omnipotent control and therefore feel that they are allowed only a narrow range of thoughts and words. Even one's movements may feel under the control of the patient. If they fidget too much, glance at the clock, clear their throat, or take their eyes off the patient, they may induce a narcissistic injury in a hypervigilant narcissistic patient.

Although the countertransference as an excluded observer and the countertransference of feeling subjugated both grow out of the patient's need to deny separateness from the therapist, these two states may feel quite different. In contrast to the excluded observer countertransference, therapists of hypervigilant patients may feel that they are anything but excluded; they may

feel under intense scrutiny, as though a police interrogation light is shining on their faces. They may not feel able to reflect on their own thoughts and allow themselves the freedom of their own associations because they feel they must comply with patients' needs for omnipotent control.

Mutual Admiration

Russ et al. (2008) identified a high-functioning narcissistic individual who may actually produce feelings of envy and admiration in the therapist, especially if the patient is charming and entertaining. Therapists may find themselves "enjoying the show" rather than working therapeutically to help the patient (Gabbard 1998). They may have difficulty recognizing that they are being treated as an extension of the self who is designed to meet the needs of the patient for validation and affirmation rather than interpreting the patient's interpersonal strategies. These kinds of therapies may end up in a stalemate of a mutual admiration society, where both therapist and patient admire and complement one another.

CONCLUSION

Although many of the countertransference developments that occur with narcissistic patients are challenging to tolerate, there is often an advantage in allowing oneself to be steeped in the transference-countertransference experience because it reflects the characteristic patterns of difficulty in relationships outside the treatment setting. The challenges inherent in treating patients with narcissistic personality disorder make brief treatment an inadequate option. These patients generally require long-term psychoanalytic psychotherapy or psychoanalysis to adequately address the entrenched problems that have haunted them throughout their lives. Hence, the capacity to contain and process uncomfortable affect states for extended periods becomes an essential component of the treatment. Therapists who prematurely attempt to "unload" these feelings may find that their patient is not prepared to accept the return of those unpleasant affects. On the other hand, those who can allow themselves to be used in the service of the patient's needs can hope to make significant long-term progress.

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MAINTAINING BOUNDARIES IN THE TREATMENT OF PATHOLOGICAL NARCISSISM

ANDREW F. LUCHNER

It is clear that narcissism is not a unitary construct that is defined solely by grandiosity, entitlement, and selfishness, but that it also manifests as deficits in self-esteem (a depleted or devalued self), lack of confidence, conformity, and hypersensitivity to slights and negativity (Dickinson & Pincus, 2003; Gabbard, 1994; Masterson, 1993; Miller, 1997; PDM Task Force, 2006; Wink, 1991). The two subtypes of narcissism have been termed *grandiose* and *vulnerable*, respectively. (See Chapter 2 in this volume for further explanation and discussion of vulnerable and grandiose narcissistic subtypes.) Patients with pathological narcissistic characteristics are among the more difficult to treat in psychotherapy because they use others (e.g., therapists) to define themselves, are fragile and easily affected by perceived slights and mistakes, and are perfectionistic in their attempts to elicit admiration from others to neutralize internal experiences of devaluation (Ivey, 1995; McWilliams, 1994). The source of self-satisfaction for narcissistic patients does not exist within themselves; thus, in psychotherapy, therapists are depended on to fulfill absent

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self-definition and self-worth. The pressure that therapists feel is a function of the demands that narcissistic patients place on them to exist as separate people and to exist as an extension of their devalued and critical self. Because patients with grandiose and vulnerable narcissism lack clearly defined boundaries between themselves and others, therapists can have difficulty managing and maintaining boundaries.

Pathological narcissistic patients may be additionally challenging to treat because of therapists' strivings for admiration, acceptance, and recognition for selflessness—core aspects of vulnerable narcissism. Many therapists tend to be giving, caring, and willing to accommodate to the needs of others, including their patients. It is hyper-responsibility, aversion to wrongdoing, and the wish to provide and take care of others that increases the probability that difficulties maintaining boundaries in psychotherapy will occur. For example, grandiose narcissistic patient characteristics may force therapists to confront their inability to help, whereas vulnerable narcissistic patient characteristics may leave therapists blinded by identification and the fantasy that providing psychotherapy can resolve past and current needs for helpfulness and selflessness. Although vulnerable narcissistic characteristics are not emblematic of all therapists, it is common to hear therapists talk about their special role in personal relationships as the one who has always been the “good listener” or the one whose friends “go to when they need to talk.” At the expense of one’s own needs and authentic responses in the moment, therapists may have learned early to deny their own self (e.g., denial of their own need to be gratified and attended to) as a way to feel some sense of self-worth, identity, and helpfulness to others. To care more about others than oneself has been linked to the choice of psychotherapy as a profession (Miller, 1997), and therapists are drawn to want to be the most helpful, the most effective, and the most sought out for their ability to engender change.

The interaction between characterological qualities of many therapists and the vicissitudes of therapeutic practice make working with patients with pathological narcissism challenging and taxing. As a result, psychotherapy with narcissistic patients affects therapists' ability to attend to therapeutic boundaries that are a necessary component not only for patient care (e.g., managing the therapeutic relationship) but for therapist self-care as well (Kottler, 2010; McWilliams, 2004).

This chapter begins with a discussion of boundaries and their definitions and further delineates the susceptibility of therapists to patients with vulnerable narcissism. The link between patient pathological narcissism and boundaries is then addressed, emphasizing how different patient characteristics may lead to separate struggles with maintaining boundaries within the context of the therapeutic relationship.

BOUNDARIES AND BOUNDARY MAINTENANCE

Although there are no specific American Psychological Association (APA) ethical standards that pertain to the maintenance of boundaries, psychotherapists widely agree that boundaries play a crucial role in the therapeutic process (Gelso & Hayes, 1998). The establishment of boundaries is directly related to the professional standards of conduct, notably the importance of upholding the principle of Beneficence and Nonmaleficence (APA, 2002). However, clear definitions and clear agreement of what differentiates healthy boundaries from boundary violations are lacking (Gabbard & Lester, 1995; Glass, 2003; McWilliams, 2004). For the purpose of this discussion, *boundaries* are defined as therapeutic limits that allow for the protection of the patient'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 patient's difficulties as they relate to therapeutic goals, reducing or attending to the role of therapist opinion, and enhancing opportunities to increase patient 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 patient and not motivated by therapist needs, wishes, or agendas (Smith & Fitzpatrick, 1995). When boundaries are compromised, boundary transgressions occur, which exist on a continuum ranging from *adaptive* (i.e., ethical and therapeutically useful boundary crossings) to *maladaptive* (i.e., antitherapeutic and unethical; Frank, 2002; 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 anyone involved in the therapy, and occur when the therapist crosses the line of appropriate, decent, and ethical behavior (Zur, 2007). Furthermore, boundary violations are characterized by an absence of attenuation, involving the therapist's inability 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 patient (Gabbard & Lester, 1995; Smith & Fitzpatrick, 1995; Zur, 2007). Some examples of boundary violations include establishing romantic and sexual relationships with patients and manipulating patients for financial gain.

It is important to emphasize that boundary crossings in isolation are not inherently pathological, negative, or to be avoided (Wolf, 1988). Some interventions that cross boundaries are potentially therapeutic (Luchner, Mirsalimi, Moser, & Jones, 2008; Smith & Fitzpatrick, 1995; Williams,

PATHOLOGICAL NARCISSISM: IDENTIFICATION AND COUNTERIDENTIFICATION

It has been noted that patients who are vastly different from their therapists may provide the greatest challenge to treat; they tend to defy therapist attempts to help, to be empathic, and to model balance within therapy (McWilliams, 2004). It is equally important to consider the power of identification and how strongly therapists are drawn to patients that remind them of themselves. Similarities between therapists and patients may compromise the ability of the therapist to be a participant observer, as the wish to assist patients becomes the wish to heal oneself and to provide what the therapist never received from others. At times, therapists overidentify and become overinvolved in their patients' concerns and progress, because patients remind therapists of themselves and their own internal struggles. At other times, therapists struggle to identify with patients that they perceive as different, especially if they flaunt their grandiosity, arrogance, or self-assuredness.

Feeling satisfaction for attending selflessly to the needs of patients is most likely to be frustrated when working with patients with grandiose pathological narcissism or gratified when working with those possessing more vulnerable traits (Ivey, 1995). As might be expected, it is the grandiose patient who most obviously creates discordance in treatment and leads therapists to feel used, engulfed, and exploited (Shulman, 1986); experience fantasies of avoidance; struggle with conflict and anger; and harbor guilt and fears of ineptitude, failure, and responsibility. Because therapists "identify with victims rather than with oppressors" (McWilliams, 2004, p. 105), working with patients who exhibit grandiosity, entitlement, and selfishness is particularly taxing. However, therapists working with patients suffering from pathological vulnerable narcissism are susceptible to imposing their own needs onto patients and identifying too strongly with the deficits of patients (e.g., selflessness, subversion of needs to serve others, empathy, attunement to others' needs). It seems reasonable to expect that patients who are likeable, approachable, agreeable, and giving remind therapists of themselves and their struggles to be liked, respected, and appreciated, thereby potentially creating blind spots and boundary maintenance difficulties. Conversely, patients whom therapists dislike pose specific problems with maintaining therapeutic boundaries and managing boundary crossings because therapists want to be admired for their empathic attunement and selflessness. There are no rules for determining whether one type of patient may compromise therapeutic boundaries more or less. Yet, awareness of how patients with narcissistic pathology affect the therapeutic relationship and compromise therapists' ability to maintain intentional delivery of interventions and interpretations remains a crucial aspect of understanding narcissistic pathology in patients and recognizing

when narcissistic difficulties are affecting therapeutic work for patients and therapists alike.

BOUNDARIES AND PATHOLOGICAL NARCISSISM

Although it is difficult to anticipate how a particular therapist will react to a particular patient, some common themes regarding boundary crossings and maintenance have emerged in the clinical literature and pertain specifically to work with patients with narcissistic pathology. Because the potential for difficulty in maintaining boundaries with narcissistic patients exists specifically because of identification and counteridentification, it is important to highlight areas or indicators of boundary crossings that might exist or appear in therapy (Ivey, 1995). Each of the following sections addresses the connection between areas of potential risk for boundary transgressions based on specific traits of vulnerable and grandiose narcissism. I hope that this discussion encourages self-reflection, self-awareness, consultation, and supervision as these themes emerge within the unique context of the therapeutic relationship.

Overinvesting in Caretaking or Overinvesting in Rejection: The Misuse of Empathy

Patients with vulnerable narcissism are challenging because they tend to pull from therapists approval, advice, soothing, caretaking, and overinvolvement that ultimately affects the therapeutic process and the boundary between patient and therapist (Wolf, 1988). Therefore, the pull to bolster the self-esteem of the patient with vulnerable narcissism may involve a misuse of empathy; the therapist may erroneously believe that empathy entails "doing something good for the patient" (Wolf, 1988, p. 132) and performing acts of kindness (Gabbard, 2009). For example, the therapist, in an effort to reduce negative reactions in the patient, may attempt to emphasize positive aspects of the relationship (e.g., progress, closeness) and deemphasize any negative aspects (e.g., failure, ruptures) that may be affecting the therapeutic relationship (Miller, 1997). Controlling the discourse in therapy so that only positive experiences occur may be conceptualized as empathy, but it can be problematic because it leads to overinvestment in taking care of the patient. By extending sessions past normal time limits and by making special concessions, the therapist may be trying to protect the patient from negative experience, sacrificing boundary maintenance in an effort to avoid creating an atmosphere where negativity exists. Additionally, a psychotherapist may pay an inordinate amount of attention to the patient's strengths, avoid confrontation, and constantly reframe patient difficulties in an attempt to reduce

their own and the patient's discomfort with negativity. Difficulties accepting patients' negative reactions may create an environment in which patients cannot see the therapist as anything but positive and may serve to convey the message that negative emotions should be avoided because they may injure others. This may serve to reinforce patients' expectations that they must take care of the therapist and support the belief that they too must negate their feelings of anger and frustration in an attempt to remain close to others. The freedom for the patient to express the full range of human emotion and see the therapist as human with flaws and inabilities is thwarted, thereby possibly halting movement toward change (Wolf, 1988).

Reactions to grandiose narcissistic characteristics of grandiosity and entitlement may leave therapists unable to invest emotionally, leaving them unempathic, critical, and rejecting (Glickauf-Hughes & Wells, 1997; McWilliams, 1994). Particular emphasis on the negative aspects of grandiose narcissistic patients may be tempting because the constant devaluation and scorn that such a patient expresses may lead therapists to withhold empathy (Ivey, 1995; Shulman, 1986) or to make "vengeful comments or ill-advised management decisions as a way to get back at the patient" (Gabbard, 1994, p. 483). Therefore, therapist rejection may reduce opportunities for grandiose narcissistic patients (once a therapeutic relationship has been firmly established) to admit to or express any need of or dependence on the therapist. As empathy provides the necessary conditions for full disclosure of an integrated self, one made up of independent and dependent strivings, an absence of empathy is tantamount to rejecting the patient's need and wish to feel understood and supported. Empathy provides the necessary boundary that allows for a full range of experience by the patient. Therefore, erosion of empathy that creates rejection of the patient's inherent worth reaffirms the patient's need to protect oneself from showing weakness, vulnerability, and fallibility—core fears of grandiose narcissistic patients. Insufficient empathy may ultimately lead to treatment failure (Ivey, 1995; Wolf, 1988).

Attempting to Engender Closeness or Attempting to Engender Distance

Closeness to and "tranquil union" (Shulman, 1986, p. 146) with patients is a common experience when working with vulnerable narcissistic patients (Shulman, 1986). Therapists are drawn to patients who appear selfless, weak, and helpless, and vulnerable narcissistic patients often implicitly communicate fantasies of rescue and merger (Wolf, 1988). Although attraction to and interest in patients are expected and understandable phenomena, overinvestment in how close therapists feel toward patients may limit authenticity in treatment. The closeness that therapists feel toward their patients may limit therapeutic flexibility and an awareness of negative countertransference reactions.

Additionally, awareness and understanding of patients' experiences may be limited as therapists are drawn to join with patients who yearn to be close to and known by others. For example, therapists working with patients who exhibit vulnerable narcissistic traits may struggle to separate their own experience from that of patients, potentially leading to misguided reflections, validations, and interpretations. Therapists may believe that they can understand their clients because they are the same (thinking to themselves, "I know how you must feel") and therefore share similar reactions, perceptions, and experiences. Patients may ultimately feel like they must acquiesce to attempts to engender closeness to avoid separation. Additionally, patients may accept attempts by the therapist to provide understanding while simultaneously believing that they must agree in order to receive approval and remain close to the therapist, leading to further entrenched inauthenticity and selflessness.

Boredom is a common countertransferential reaction when working with patients with grandiose narcissistic characteristics; it takes many forms, including daydreaming, tiredness, detachment, forgetfulness, and an inability to focus attention (Gabbard, 2009; Ivey, 1995; Kernberg, 2004). Boredom ultimately creates psychological and emotional withdrawal (Glickauf-Hughes & Wells, 1997), limiting therapists' ability to attend to patients, track therapeutic dialogue, or attend to the therapeutic relationship (McWilliams, 2004). The distance that is created as a result of the grandiose narcissistic patient's attempts to separate from and not be dependent on the therapist causes difficulty for the therapist in attempting to attend to the patient, possibly recapitulating the patient's past experience of being ignored, invalidated, and devalued. For example, psychological and emotional distance from the patient (e.g., the sense that "I am too different to understand or relate") with grandiose pathological narcissism may compromise the ability of the therapist to be a participant observer; the therapist might withdraw from participation in the relationship and become unable to observe, recognize, or inquire about cognitive-affective phenomena that arise.

Devaluing and Criticizing or Idealizing and Praising: The Role of Therapist Self-focus

Vulnerable narcissistic patients "respond to their falling short by feeling inherently flawed rather than forgivably human" (McWilliams, 1994, p. 174). Therapists might misinterpret the patient's internal experience of devaluation as a therapeutic failure; their constant criticism of themselves is likely to set the stage for a multitude of difficulties that can compromise the therapeutic relationship and the treatment itself. These difficulties may include being less responsive, more hesitant, less attentive, and more doubtful about

accomplishments, therapeutic gain, and therapeutic ability. As a result, therapists who struggle with doubt about their effectiveness focus too much on their own performance, potentially replicating patients' past experience of feeling unimportant and devalued themselves.

A significant trap that therapists can easily fall into when working with patients who display grandiose narcissistic tendencies is identification with the patient's grandiose and inflated sense of self (Coen, 2007; McWilliams, 1994). Such patients can be charming, extroverted, and attractive, qualities that therapists may aspire to but have difficulty owning and believing apply to themselves. By using these qualities, patients with grandiose narcissism can be very convincing in their attempts to exude greatness and infallibility. Therapists can easily be drawn to patients' grandiose presentations and collude with them in believing in their greatness and also begin to identify with this illusion (Gabbard, 2009). For example, therapists may become increasingly confident about their abilities, such as their greatness to heal, attend, and help. Idealization may result in both parties reinforcing grandiose and entitled strivings, never allowing for growth or challenge of grandiose behavior and defense.

Taking Responsibility or Avoiding Responsibility

Vulnerable narcissistic patients tend to attribute too much error to their own behavior; they feel that they must perfectly attend to others or be rejected and left without purpose. In turn, they may create in therapists the wish to protect, increasing the therapist's susceptibility to taking too much responsibility for lack of progress and difficulty in the therapeutic relationship. Because patients with vulnerable narcissism come across as selfless, eager to assist, giving, agreeable, and caretaking, therapists may feel guilty when they become aware of a lack of improvement or change. For example, therapists may take responsibility for blame too easily or too often when patients express self-blame or fault in terms of lack of progress. Therapists who excessively admit fault and vulnerability may inadvertently reinforce self-devaluation and self-blame to vulnerable narcissistic patients. Boundaries are compromised when patients shift attention to managing therapist distress, placing patients with vulnerable narcissism in the familiar role of caretaker and protector of others.

Patients who exhibit grandiose narcissistic characteristics challenge therapists to admit vulnerabilities, fallibilities, and mistakes, the same fears that exist for the patient. Grandiose narcissistic patients pull therapists to disown their own sense of responsibility and blame the patient for the lack of progress, for difficulty establishing a therapeutic relationship, and for negative countertransference feelings (e.g., anger). In turn, the therapist's inability

to accept responsibility may limit the ability of patients to accept their own fallibility, denying them self-expression and subjective experience. For example, a therapist may communicate that patients are “responsible for their own change” while thinking that patients’ lack of change is “not my responsibility.”

Unconditionally Accepting or Competing and Arguing

The patient with vulnerable narcissistic tendencies often attempts to demonstrate to the therapist his or her capacity to provide constant affection and admiration. As a result, the therapist may feel obligated to unconditionally accept the patient and return the experience of admiration and affection (especially if the therapist struggles with similar difficulties). Boundary transgressions of a more implicit nature can occur as a result of the wish to provide unconditional acceptance (and at its most extreme, love) of the patient. For example, the psychotherapist may frequently and persistently attempt to actively soothe the patient, potentially compromising boundaries because of the motivation and wish to be the perfect parent who is capable of providing unconditional love to the child (Gabbard & Lester, 1995). Improvement in therapy for patients, however, may become increasingly difficult to achieve because therapists’ attempts to provide unwavering acceptance may stunt patients’ 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 patients in the familiar role of providing constant support and comfort to others. For example, providing unconditional acceptance may leave patients unexposed to the inevitable and necessary frustration inherent in therapeutic work that ultimately contributes to motivation for and awareness of change, depriving them of the opportunity to develop their own internal means (e.g., confidence) for self-soothing.

The seeming self-assuredness and sense of entitlement of patients with grandiose narcissism invites therapists to argue, confront, and be competitive with them (Gabbard, 2009) in an attempt to show or prove to them that their sense of grandiosity is false and not based in reality. Additionally, therapists may feel annoyed, frustrated, and angry at patients who constantly attempt to prove their infallibility and perfection; they may become overly invested in arguing and competing with their patients as a result of their own struggle to manage negative reactions (e.g., criticism, condemnation) toward them (Kohut & Wolf, 1986; Masterson, 1993). Therapists may engage in competitive strivings to win arguments, prove their worthiness to their patients, or prove the unworthiness of the patient’s grandiosity. As a result, argumentativeness may ultimately lead to further devaluation, leading to entitlement in the therapist. For example, a therapist may become competitive and argumentative

of omnipotence serves to eliminate the experience of frustration and pain, that of a humiliating sense of need or dependency, and related feelings of envy. (Of whom would an omnipotent, grandiose self be envious?) When enacted interpersonally, the narcissistic patient unconsciously seeks to omnipotently control others, as if to guarantee the admiration, validation, or accommodation from others that he requires. The patient's sense of omnipotence is threatened, and the prospect of actualizing some limitation or failure becomes more real, when he comes into increased contact with the demands posed in his work situation or relationships. It is for this reason that many narcissistic patients functioning in the BPO range have difficulties in work and relationships, often responding to the reasonable demands of the same with an indignant withdrawal from real-life commitments.

In contrast to typical cases of borderline personality disorder, which are characterized by extreme and unpredictable shifts in the self- and object representations activated in a given moment, the narcissistic dyad is often particularly stable and, for periods of time, inflexible. The artificially stable pathological grandiose self is kept firmly in place through the use of primitive defenses, such as omnipotent control, which involves the use of aggression, the threat of aggression, and the induction of a "walking on eggshells" feeling in the therapist and others. Such control facilitates an avoidance of any sense of inferiority, injuries to self-esteem, or anything that would suggest to the patient something lacking in the self and residing in others, something the patient might need to depend on or might envy. Unconscious as well as conscious feelings of envy may lead to the impulse to destroy the good aspects and experience of others, particularly those qualities admired in the other but that one does not possess (Kernberg, 1984; Rosenfeld, 1964). Pathological envy is a dominant experience and ever-present threat for narcissistic patients, one that is frequently warded off in the clinical process through the patient's grandiosity and devaluation of others, including the therapist. Idealization allows the patient to feel admired by those surrounding him, individuals and institutions worthy of his company and communion. Paradoxically, however, the patient needs to devalue those same individuals in order to stave off the awareness of any humiliating deficiency in the grandiose self, as well as feelings of envy. The episodes of rage characteristic of many narcissistic personalities (Kernberg, 2003; Kohut, 1972) reflect threats to or breakdowns in the pathological grandiose self, incited by situations in which the patient is forced to confront some aspect of reality that challenges the splitting off of negative self representations or that does not suit the patient's narcissistic needs at the moment (to have their brilliance reflected and admired by a brilliant object/therapist, or to be perfectly understood). When operating effectively (from the patient's perspective), this defensive style complicates the treatment process by contributing to a strong subjective sense of superiority and

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KOHUT'S SELF PSYCHOLOGY APPROACH TO TREATING PATHOLOGICAL NARCISSISM

M. DAVID LIBERMAN

Heinz Kohut was born in Vienna in May 1913. He graduated from the University of Vienna medical program in 1938 and emigrated shortly afterward. "Kohut, like Freud, initially started out in Neurology and did so, reportedly, quite successfully" (Strozier, 2002, p. 44). Kohut published a number of papers as well as two books that were both groundbreaking and controversial. These publications began his career-long reconsideration of the basic tenets of psychoanalysis. His ideas continued to evolve until his death in 1981. Kohut's last book was published posthumously.


SELF PSYCHOLOGY: AN OVERVIEW

Self psychology is the school of psychoanalysis that grew out of Heinz Kohut's work. Kohut, a classically trained psychoanalyst, was thoroughly steeped in the ego psychology of the time. However, his experiences with

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narcissistic patients ultimately led him to develop a radical reformulation of psychoanalytic theory and practice. Classical analysis held that there was one developmental line that reached from narcissism (i.e., self-investment) to object love (i.e., the ability to invest in others) and that the narcissistic individual was someone who had failed to progress along this continuum. Kohut proposed a very different conceptualization. He believed that there were two normal developmental lines. One of these was the development of object relations as described by Freud. The other, equally important, line was the developmental line of narcissism. Kohut began to understand narcissism as an immature or yet-to-be-developed form of self-esteem. The narcissistic individual is “stuck” and needs to resume the development toward mature self-esteem and a resilient sense of self (Kohut, 1966). In so doing, Kohut removed from narcissism the stigma of being implicitly pathological. In classical psychoanalysis, it was believed that narcissistic patients were incapable of developing transferences. Freud (1912/1958) saw the development of the transference as absolutely crucial for successful treatment. In the psychoanalytic thinking of the time, the inability to develop a transference meant that the patient was unanalyzable (i.e., untreatable). In a second major departure from the classical analytic position, Kohut clearly stated that individuals suffering from narcissistic disorders did, in fact, develop transferences, albeit of a different variety, and were therefore treatable (Kohut, 1968).

EVOLUTION OF SELF PSYCHOLOGY THEORY

Initially, Kohut attempted to fit his ideas into prevailing psychoanalytic thought and phrased his understanding in the metapsychological language of the time (Kohut, 1971). Eventually, however, he began to offer a different vision of psychoanalysis. Stolorow (1978) referred to Kohut's new framework as a

psychology of the self . . . The phrase “developmental phenomenology of the self” would be more accurate since it is concerned with the ontogenesis of the self-experience, its conscious and unconscious constituents, and their normal and pathological developmental vicissitudes. . . . In short, Kohut enjoined analysts to shift their conceptual framework from one that assumes the motivational primacy of instinctual drives to one that postulates the motivational primacy of self-experience. (p. 329)

By the end of his life, Kohut had clearly separated his ideas from classical psychoanalysis. Rather than seeing psychopathology as resulting from a clash among psychic structures caused by difficulties in drive processing, Kohut envisioned a psychoanalysis that focused on the individual's self experience and how it might reflect successful and failed experiences with past relationships.

THE SELF

Although he was known to be very precise in his definitions of all matters psychoanalytic, Kohut remained purposely imprecise in his definition of the self. He later explained that he was deliberately vague in his discussion of how the essence of self should be defined because it was not possible to know the essence of the self. "Only its introspectively or empathically perceived psychological manifestations are open to us" (Kohut, 1977, pp. 310–311). Kohut considered the self to be a "comparatively low-level, i.e. comparatively experience-near psychoanalytic abstraction" as compared with the ego, id and superego, which are "high level, i.e., experience-distant, abstraction in psychoanalysis" (Kohut, 1977, pp. 310–311). Furthermore, he described the self as "a content of the mental apparatus" and that "it has continuity in time, i.e., it is enduring" (Kohut, 1971, pp. xiv–xv). Self psychology thus became the psychoanalytic study of our ongoing self experience as we perceive its continuities and discontinuities.

HEALTHY DEVELOPMENT

Kohut (1959) was convinced that empathy was absolutely crucial to psychological development, referring to it as the "oxygen" of self development, without which the self would not develop (Kohut, 1977). Serious empathic failures by the child's caretakers would cripple the developing self and leave it open to fragmentation and collapse. According to Kohut, there were two requirements for healthy self development. First, there was a basic "intuneness" or empathic connection between the caretakers and the child. Second, psychic structure was developed because of nontraumatic failures in empathy by the child's caretakers. Kohut referred to these nontraumatic failures as *optimal frustrations* (Kohut & Seitz, 1960). This meant that the child was disappointed just enough to be able to absorb the frustration of an unmet need without being overwhelmed by the feelings of frustration. Kohut's view was that human beings needed to feel understood throughout the life span and that these developments prepared the developing self to get this need for understanding filled by engaging in more mature relationships (Kohut, 1984).

The healthy child was envisioned as initially born into a blissful state of tensionless existence. Empathically attuned parents provide for the child's comforts, and the child is unaware of an inner or outer world. In time, the child becomes uncomfortably aware that all is not perfect, as the environment fails to seamlessly provide for his or her needs. In an attempt to hold onto that original blissful state, the child develops a belief in his or her own perfection and omnipotence and that all "good" resides within. Kohut

initially termed this state of the child's perception of being perfect as the *narcissistic self* (Kohut, 1966) and later changed the term to the *grandiose self* (Kohut, 1968). The child's feelings of "greatness" and perfection are mirrored back to the child by the parents through their constant attention to his or her needs. "This attention reassures the child of its greatness, vigor and perfection" (Kohut & Wolf, 1978, p. 413).

Selfobjects

As a result of continuing optimal frustrations, the child begins to develop some awareness that there is something else "out there." At this point, the child would not see these others (the psychoanalytic term for *other* is *object*) in his or her environment as separate people but as actually part of himself or herself. Kohut described these "others" as narcissistic objects and later renamed them *self-objects* to convey the sense of the child that these others were really part of himself or herself much in the same way as an adult would see an arm or a leg (Kohut, 1971). Later still, he eliminated the hyphen between the words *self* and *object* to convey even more dramatically the image of merger.

Eventually, the child becomes more aware that the selfobjects respond to its level of tension. The child feels empathically merged with his or her parents, and this allows him or her to feel that the parents' tension-regulating capacities are actually part of the child. This merger leads to the child's development of the grandiose self (Kohut, 1968). Kohut saw the development of the grandiose self as ultimately supplying the child with the ability to regulate tension, self-soothe, and feel vigorous and joyful.

Simultaneously, the child becomes increasingly aware that these others also provide a feeling of calm, security, safety, and power that can protect the child and dispel fears when he or she feels threatened or helpless. The child idealizes these others and sees them as all knowing and all powerful. Kohut termed these others the *idealized parent imagoes* (Kohut, 1971, p. 25). They become the external representations of the child's former feeling of omnipotence. The developing child empathically merges with the idealized parent and feels that the parents' calmness, power, and wisdom are also part of himself or herself (Kohut, 1966).

The Role of Frustration

Because of continuing optimal frustrations, the mirroring and idealizing functions of the parents are ultimately converted into a psychic structure by the child through the process of transmuting internalization—*transmuting* inasmuch as the raw idealization is changed into a more realistic appraisal

and freed of its painful origins and *internalization* as it steadily becomes part of the individual's own psychic structure. The child then takes some small portion of these processes and makes it part of his or her own mind. Successful internalization takes place in a way that is both fractionated and removes the "personal" elements from what is internalized (Kohut, 1971). The child is able to take over the soothing and admiring functions of the mirroring selfobject as well as the calming and inspiring functions of the idealized parent imago. For Freud (1917), the mourning process was necessary to the development of psychic structure through the process of internalization. Kohut saw a similar process taking place in the developing individual (Kohut & Seitz, 1960). Clinicians often see the same thing taking place in the clinical situation. When our patients find that we have let them down in some small way, they withdraw their idealizing or mirroring needs back from us and begin to perform these functions for themselves.

Motivation

Motivation stemmed from the synthesis of the grandiose self and the idealized parent imago into what Kohut called the *bipolar self*. The bipolar self was the inheritor of these two earlier imagoes. The mirroring of the early maternal object that accepts and confirms the child's exhibitionism and perfection becomes the grandiose self, which ultimately gives rise to the child's ambitions. The child's idealization of and subsequent merger with the idealized selfobject develops into the idealized parent imago, which ultimately gives rise to the child's ideals (Kohut, 1977). Kohut saw these two poles as being connected by a *tension arc*, which is the area of skills and talents that the individual possesses. These native skills and talents give the developing self the ability to pursue its ambitions and goals. Kohut described the self as being "pushed" by the ambitions that were developed from the grandiose self and "pulled" by the ideals that were incorporated from the idealized parent imago (Kohut, 1977).

PATHOLOGICAL DEVELOPMENT

Kohut saw the narcissistic disorders as resulting from early damage to the self-structure resulting in a defective self. It was not the content of a particular experience that was traumatic to the self but rather the intensity of it (Kohut & Seitz, 1963). A damaged self was one that was prone to weakness, fragmentation, and disharmony. This was the result of disturbances in the self-selfobject processes in early life (Kohut, 1984). Damage could result if tension relief was unpredictable or the waiting time for relief exceeded

the child's tolerance (Kohut & Seitz, 1963). Kohut identified two symptom patterns that characterized the narcissistic disorders: He found that the self-esteem of narcissistically injured individuals was very labile and also that they were extremely sensitive to failures, disappointments, and slights (Kohut & Wolf, 1978).

Disorders

Four primary categories of psychopathology were conceptualized: (a) the psychoses, in which the individual either had no sense of self or one that was seriously fragmented, such as in schizophrenia; (b) the borderline condition, in which there was a defensive covering of a psychotic or fragmented self; (c) the narcissistic disorders; and (d) the neurotic or oedipal disorders, the latter two having an intact but compromised self. Of the four, it was only the last two that were analyzable (Kohut & Wolf, 1978). Initially, Kohut believed that oedipal and narcissistic disorders could coexist in the same person (Kohut, 1977). However, by the time of his death, Kohut had begun to question whether the neurotic disorders were, in reality, just another form of narcissistic disorder (Kohut, 1984).

Kohut (1977) delineated two general types of narcissistic disorders: the narcissistic personality disorder and the narcissistic behavior disorder. In the former, the symptoms were autoplasmic; patients might seek therapy because they just did not feel right but could not say how or why. They might also experience feelings of emptiness or detachment. In the narcissistic behavior disorder, the symptoms were alloplasmic; individuals have resorted to some form of acting out, such as shoplifting, compulsive sexual activity, or substance abuse in order to calm or soothe themselves.

Narcissistic problems could be expressed in many ways. The narcissistic individual's fear of the breakdown of the self leads to a fear of fragmentation or disintegration anxiety. One patient in analysis experienced the breakdown of his vulnerable self-structure in his sleep. After he had suffered a narcissistic injury, he would report vivid dreams of being disemboweled, dissected, or eaten alive. It was not the symbolism that was important to him but the helplessness and agony that he felt in the dream.

Splitting of the self could also result. The *horizontal split* was something that was long established in classical analysis. This was the separation of conscious from unconscious processes. Kohut described the *vertical split* in which two ideas that are totally contradictory could simultaneously exist in consciousness without the individual seeing the contradiction (Kohut, 1971). A former patient used to complain bitterly about his wife's weight. She was terribly heavy and did not seem to be doing anything about it. Yet he would go shopping and bring home large amounts of sweets and other tempting

foods. He was incredulous when I questioned this. He knew that she overate and that her weight upset him, but he could not understand what his shopping choices had to do with that. Another consequence of the weakened self can be episodes of narcissistic rage. Kohut viewed these narcissistic rages as the response of a weakened self structure to some threat to its already fragile integrity and described the considerable intensity of the anger that his patients would display toward him when they felt either misunderstood or wronged in some way (Kohut, 1977). Kohut noted that unlike healthy aggression, the motive for these rages is a feeling of revenge or of an unfairness that had to be righted (Kohut, 1972). I have worked with a number of men and women who, on discovering their spouse's infidelity, experienced intractable rage, which they struggled with for years as a narcissistic injury that could not be absorbed.

NR!

Causes

Self psychologists believed that narcissistic disorders resulted from failures in necessary self experiences with either the mirroring that is needed for development of the grandiose self or in some disruption of the idealization process between the child and the idealized parent imago. If there have been failures in mirroring, then the grandiose self will continue to strive for fulfillment of its archaic aims. One patient had been told by his mother that he could do anything, including being president of the United States. He was convinced that she was right, and he continued to struggle to achieve this end. Lesser achievements meant nothing to him. If there had been failures in idealization, then the individual may feel helpless and will continue searching for someone to idealize and with whom to merge. One somewhat well-known local mental health professional had become a bit of a professional "embarrassment" as he was known for going from sitting at the feet of one famous psychiatrist to sitting at the feet of another, seemingly in a continuing search to find an all-knowing other.

TREATMENT

The process of self psychological treatment is like other forms of psychoanalytic therapy: The patient attempts to speak freely while the therapist listens and makes interpretations, paying particular attention to the transferences that arise. Kohut (1984) wrote that for a successful treatment "the analysand must be able to engage the analyst as a selfobject by mobilizing the sets of inner experiences that we call selfobject transferences" (p. 70). Kohut believed that it was absolutely necessary that the therapist be truly able to

DYNAMICS OF PATHOLOGICAL NARCISSISM

Heinz Kohut (1971) described the core dynamics of pathological narcissism as flowing from the developmental failures that impede both the growth and maturation of the basic structures of the self and of the progressive relatedness of the evolving self to the world of objects. Such relatedness grows from childhood through an appropriately primitive (i.e., selfish) use of objects at the service of the self (self-objects) and goes on to achieve mature relatedness and adult mutuality. Such developmental failures may affect the attainment of a personal identity and of mature love.

If this healthy process is not accomplished, the person's identity is impaired by repressed childlike, immature, grandiose self-images. The repression of such entities requires significant and tiresome efforts on the part of the ego, and the control is, in any case, so tenuous that the person often lives in dread of a breakthrough of such primitive experiences—experiences such as a grandiose sense of self-importance; a preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love; and the belief that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people.

A second set of consequences of the developmental failures that give rise to pathological narcissism affect the person's relationships to others. To the degree that such relationships are suffused with omnipotence and magical thinking, they are also plagued by endless conflict: conflict generated by the patient's overt or covert demands for excessive admiration and by their feeling entitled to especially favorable treatment. These patients are often interpersonally exploitative, lack empathy, are envious of others, and demonstrate arrogant, haughty behaviors or attitudes.

In addition, persons suffering from pathological narcissism experience shame as a characteristic main affect. Shame is mobilized when the narcissistic person fails to live up to his grand self-image or when suffering the perceived interpersonal slights to which narcissistic individuals are ever so sensitive. The shame is intertwined with a tyrannical perfectionism that imposes impossible demands on the person and on others. This perfectionism may serve to compensate for the conscious or unconscious sense of inferiority that often plagues these patients and may also fuel the relentless drive to live up to their grandiose fantasies. This perfectionism may extend to large domains of the person's functions such as the appearance and function of the body, sexual fantasies or activities, and emotional or intellectual dispositions. The implacable demands (on self and others) of such perfectionism erode any sense of self-esteem and may give rise to considerable self-hatred.

The overt psychopathology displayed by people with pathological narcissism relates to two sets of forces. The first is the lack of maturation,

integration, and realization of large segments of grandiose self that leads to problems of identity formation, maintenance of self-esteem, and development of appropriate and satisfying values, ideals, and accomplishments for the patient. The second pathological process involves the derailment of drive–developmental processes. In this regard, the presence of significant, unresolved self-developmental pathology affects the patient's ability to cope with object losses and to resolve triangular oedipal pathology. Kohut (1971), in fact, is said to have stated that clinically significant Oedipus complexes occur because the developing child's normal drives and conflicts were previously disturbed by unresolved narcissistic wounds related to unempathic parental responses.

SHORT-TERM DYNAMIC PSYCHOTHERAPY FOR PATHOLOGICAL NARCISSISM

I have developed a short-term treatment option for patients suffering from pathological narcissism that builds on some of the technical contributions of David Malan (1976) and Peter Sifneos (1992); Habib Davanloo (2000) in his intensive short-term dynamic psychotherapy (ISTDP); and on the contributions of Heinz Kohut to self psychology.

ISTDP was developed to deal with the problems of patients whose pathology is generated by complicated foci of oedipal psychopathology and by pathological grief resulting from object loss but who manifest intense and rigid defenses that render their unconscious conflict practically inaccessible to dynamic techniques based on free association. Meta-analytic reviews (Abbass, Hancock, Henderson, & Kiesly, 2006; Leichsenring, 2001) have found that ISTDP is effective for a variety of patient problems, including anxiety and depressive disorders or Axis II Cluster C disorders such as avoidant, dependent, obsessive–compulsive, and passive–aggressive personality disorders, precisely because it has developed techniques that can reach these affects by effectively confronting and reducing such defenses. My extensive clinical experiences suggest that modified forms of ISTDP are potentially powerful treatments for some of the problems of these patients, but they are not sufficient to mobilize and resolve the specific narcissistic unconscious pathology, constituted by rigid dissociative defenses and by primitive self and object representations.

Davanloo (2000) elegantly systematized the techniques required to obtain an early breakthrough into the unconscious of highly resistant patients. The core of Davanloo's techniques flows from his research on the twin dynamics of transference and resistance. The central aim of Davanloo's system of ISTDP is the rapid reduction or removal of resistance through a system of planned

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SCHEMA THERAPY FOR PATHOLOGICAL NARCISSISM: THE ART OF ADAPTIVE REPARENTING

WENDY T. BEHARY AND EVA DIECKMANN

Schema therapy, an integrative model of psychotherapy developed by Young, Klosko, and Weishaar (2003), was developed to treat personality and chronic symptom disorders. Included in this thoughtfully assembled, evidence-based approach to treatment (Giesen-Bloo et al., 2006) are elements from gestalt, object relations, psychodynamic, cognitive-behavioral, and emotion-focused therapies. One of the hallmark features of schema therapy is the concept of (adaptive) limited reparenting. Emphasis is placed on (a) identifying core unmet needs and attachment ruptures in the patient's early development and (b) working to help the patient get those needs met. Although no specific clinical trials of schema therapy for narcissistic personality disorder (NPD) have been conducted, anecdotal observations and reports suggest that it may have potential as an effective treatment.

This chapter discusses the use of schema therapy for NPD. We begin by discussing the primary tenets of schema therapy and then illustrate how this can be applied to the treatment of NPD.

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com). Patients with NPD tend to have the following schema modes (Young & First, 2004):

- **Vulnerable Child Mode:** feels mostly lonely, unlovable, and ashamed in response to the conditional love based on extraordinary performance along with the critical and demanding expectations for emotional control and achievement;
- **Impulsive Child Mode:** acts on noncore desires or impulses in a selfish or uncontrolled manner to get his or her own way and often has difficulty delaying short-term gratification; often feels intensely angry, enraged, infuriated, frustrated, or impatient when these noncore desires or impulses cannot be met; may appear “spoiled”;
- **Detached Self-Soothing/Self-Stimulating Coping Mode:** pursues activities in a compulsive manner (to help cut off access to painful emotions and loneliness), such as excessive work, substance abuse, intellectual dialogues, pornography, and other addictive behaviors;
- **Overcompensating Mode:** bullies, acts entitled and controlling, demands approval and attention, usually triggered by feelings of inadequacy or disregard;
- **Demanding Parent Mode:** feels that the “right” way to be is to be perfect or achieve at a very high level, to keep everything in order, and to strive for high status, typically in response to the underlying sense of defectiveness and emotional deprivation; and
- **Healthy Adult Mode:** nurtures the vulnerable child mode, sets limits for impulsive child mode and the entitled overcompensator, promotes and supports a healthy child mode, eventually replaces the maladaptive detached coping mode; neutralizes or moderates the demanding parent.

The schema mode approach allows the therapist to align with the healthy and strong parts of the patient’s personality, in an effort to weaken the maladaptive or self-defeating parts that interfere with and sabotage relationships and the overall health of the patient, as detailed in the following case example. (The patient’s identity has been disguised to maintain confidentiality.)

Therapist: Hello, Stephen.

Patient: Hello . . . Uh [looking at his watch as he takes a seat], do you think we can wrap this up a little faster today? I have a telephone conference in about an hour. I really have nothing much to talk about, and I am parked in what I believe may be a no-parking area outside. I was rushed getting here, almost canceled.

all the while maintaining an attuned awareness of the in-the-moment interactions within the therapy relationship. Schema therapists act as healthy models for patients' healthy adult mode; reorganizing biased beliefs; empathizing with, nurturing, guiding, and protecting child modes; and identifying shifts in the treatment room as a means for generalizing these experiences and response patterns to patients' daily life. For example, schema therapists notice out loud that the long-winded, condescending monologue of narcissistic patients, in response to a question about feelings, can feel burdensome and off-putting (even though they are trained to understand patients' need to avoid emotions and assume a superior role in most relationships). They point out that despite their awareness of the underlying motivation for this recognition-seeking mode, their "humaneness" detects what it might be like for significant others who lack the training to understand their makeup and simply want to feel connected. The therapy relationship is relevant to patients' therapeutic goals, such as developing reciprocity, openness, and empathy in relationships. Collaboration between the therapist and the patient's healthy adult mode promotes the healing of these lifelong patterns formed in response to the unmet needs of the lonely and deprived child. As patients become more aware of their modes and activating conditions and work to strengthen the healthy adult modes (with the help of the therapist), they experience a weakening of imbedded schema-driven inclinations and begins responding more openly and adequately to their longings, which arise from core unmet needs. They also achieve quicker recovery from the tightly held grip of turbulent emotions related to their early maladaptive blueprints.

The Issue of Therapist Competence

Finding clinicians who are willing (and specifically trained) to work with patients with NPD is a serious challenge. Yet, many therapists have a strong desire to develop the clinical skills necessary to treat such patients. Therapists often reveal that no matter what method they have used, there is rare "success" with NPD patients. Thus, most therapists choose to not work with them, because they expect enduring change to be a hopeless endeavor. Additionally, it is not uncommon for therapists to state that they experience their own intense schema activation when working with these patients, making their access to empathy untenable. There are probably few patient populations that can provoke the same sense of intimidation, incompetence, anger, and self-doubt as narcissistic patients. During training and supervision in schema therapy, a good deal of time is spent on *parallel process*, meaning that for therapists to become sturdy, credible, and competent experts with this population, they need to heal personal schemas and modes that are likely to be triggered by the narcissistic patient, who can become highly critical of the therapist's credentials, style, and even office décor. It is not uncommon for cli-

on him because she needed him to bolster her sense of security and worth; she praised him for being the “special child” but didn’t stand up to the other parent (usually the father), who was unavailable, critical of his performance, and placed high demands on the child to be extraordinary (i.e. the concept of never feeling good enough, except through third-party boasting to friends, family, and “important” people). The child learns that it is not enough to simply be a spontaneous, curious, playful, and lovable little person. Success and celebrity-like stature in the community have sometimes gained these families a type of special VIP status. The child is expected to meet the obligations of an ascribed child prodigy. As the child grows, he learns that he is entitled to live by a separate set of rules, different from the “ordinary people” in the world.

But NPD is not limited to a “high society” family, nor is such a family background an absolute predictor for narcissism. A schema profile of narcissism can also be anchored to an average family where the mother was passive or depressed and needed her child to be the strong side of her. The father may have been a man who worked long hours, drank too much, and had little time or tolerance for his son’s needs for love and attention. His interests and enthusiasm regarding his child may have been mostly based on the child’s competitive self-expression and productivity. The child’s need for a genuinely secure sense of connection and acceptance is exchanged for the relief he finds in the absence of his dad’s disappointment, criticism, and disdain for his innate emotional longings.

As patients learn about their modes, schema therapists help them to choose suitable terminology to identify their Lonely Child, Detached Side, and Self-Aggrandizing Side. Patients find it more emotionally illustrative and less clinical when they use personal expressions to characterize their modes. For example, we know of a patient who referred to his detached side as “Freezer Boy” and the lonely child as “Lost Edward.”

(Vulnerable) Lonely Child Mode

Emotional deprivation is a hallmark schema for narcissistic patients because the need for physical and emotional affection, protection, guidance, and understanding was not adequately met. Instead, the only attention or praise the child received was conditioned by his meeting certain expectations. He learned to be loved for “doing,” not “being.” Yet, approval for a well-done performance did not meet the child’s need for a secure attachment. Patients will sometimes state that they still feel deprived, inadequate, and lonely, in spite of immense success. However, unaware of the impact of this void in the parent-child relationship, they often respond to initial interviews by casually stating that their childhood was “normal.” This extraordinary form of detachment is akin to forgetting that you are starving. We can also view it as a type of habituated adaptation.

In addition to the deprivation of positive attunement, any sign of emotional neediness—the need to be held, hugged, comforted, reassured—is deemed a weakness and is met with either direct criticalness or further withdrawing of attention and praise, leaving the child feeling ashamed and defective for having these (natural) needs. This creates the onset of the defectiveness–shame schema. Our patients express sentiments like, “I learned to not need anyone, from the age of four. I was dedicated to just working hard to get the goodies.” And when asked, “But what happened to ‘little so-and-so’?” they usually reply with, “He’s gone—and good riddance. He was too weak, too sensitive.” What the patient is describing is the detached, self-soothing mode that was constructed early on as a way of not feeling the pain associated with his emotional loneliness and his sense of shame and insecurity. The absence of this important needs constellation, founded in secure attachments, can have implications for treatment, informing clinicians of the deeply imbedded implicit belief that no one could ever really love and understand him just for being him.

Detached Protector (Self-Soother) Mode

Many (enlightened) patients with NPD say that they had to become hyperautonomous and self-reliant so that they would never have to count on someone else to be there for them. Their unrelenting standards schema is often spawned by the high expectations put forth by their parent(s), along with a striving for the kind of perfection that puts them at the top of the heap, where others can only look up to them. They find places to turn their attention to ward off and soothe the empty feelings of the lonely, vulnerable child within their implicit memory. The Detached Protector (Self-Soother) is one of the default modes of patients with NPD. Some examples of this (maladaptive) mode in adult patients include a variety of compulsive behaviors, such as working, gambling, eating, drugs, alcohol, spending, pornography, sex, debates, and intellectual monologues.

Because mom essentially “used” the child for her own sense of purpose and connection, the child develops a mistrust schema, the idea that people are nice only because they want something. In therapy, patients with NPD tend to be moderately suspicious of kind and caring gestures toward them. They may even mock the therapist for being too sensitive or too soft. One of our patients once said, “You’re paid to care about me. What kind of real care is that?” The reply was:

You pay me for my training and expertise in guiding this process and understanding your makeup. You cannot pay me to care for you. I either do or I don’t. So, if I do—it’s free. It’s on me. But when you accuse me of being manipulative and use that critical tone, it’s hard to care about you. That’s on you.

(Overcompensating) Self-Aggrandizing Mode

The “fight” or overcompensating mode is also used to cope with the triggering of schema clusters. Narcissistic patients are likely to show up as overly charming, entitled, competitive and aggressive, controlling, or critical. They can also show up impatiently in treatment rooms, with little to no tolerance for “things” (including approval and recognition) not coming easily and rapidly to them. This is when they are likely to yell, demand, embarrass, and dominate the people who they perceive to be a threat to their immediate comfort and security. This is another (disowned) method for keeping the lonely and shameful little boy tucked away, never to be felt, never again to be ignored or punished. Narcissistic individuals engage in human interactions as if they are in a game, consistently manipulating their sense of importance and acceptance by maneuvering the “one up—one down” position.

Other Modes

The demanding parent mode—the one responsible for the undying competitiveness, unrelenting standards, and compulsivity—is almost always operating just a scratch below the surface, much like the stage mother who refuses to relinquish her post just beyond the curtain. The healthy adult mode is present when the narcissistic patient is not reacting to a triggering condition and has not flipped into a maladaptive coping mode.

GOALS AND STRATEGIES

The chief goal in schema therapy for patients with NPD is to weaken the maladaptive coping modes, so that the lonely child can be accessed for reparenting, first by the therapist and eventually by the healthy adult side of his personality and ultimately by others who have chosen to remain in his life. As a result, he learns to drop his guard(s) and empathize not only with the resonant feelings coming from his early internal world but for others as well. In so doing, he creates the opportunity for intimacy with others. The therapist may use imagery and chair work to facilitate dialogues for the purpose of schema mode differentiation and to assess the relevant strength of the modes. These strategies are also aimed at freeing and re-parenting the lonely child and at helping the healthy adult side confront the detached and entitled sides (Kellogg, 2009; Young et al., 2003).

Experiential or emotion-focused techniques are also used (Behary, 2008a). For example, the therapist uses *self-disclosure* in an effort to generalize micro clashes in the therapy relationship to macro clashes in the patient’s

very thing that perpetuates it. He starts out as the entertaining, bright, and witty guy in the room. But as soon as you attempt to reach beyond his wall of masterful trivia or profoundly esoteric stories to his emotional side, he excuses himself for an "important call" or glazes over and becomes bored, annoyed, or distracted. He may also attempt to turn the tide, asking why you would ask such a "foolish" question.

There is irony in the fact that the response pattern (when he is uncomfortable) that causes those in his company to often find him unbearable, undesirable, boorish, and obnoxious is the very thing he is trying to avoid. He merely wants to fit in, and the only way he knows how to achieve this is by grandstanding and attention seeking or by shutting down and distracting himself. The major idea behind empathic confrontation is, "It's not your fault, but it is your responsibility to do something now."

Obstacles in Treatment

The change phase of treatment can take a good deal of time, sometimes lasting 1 to 2 years or more, depending on other comorbid issues. The narcissistic patient, with little frustration tolerance, may not withstand the process. There may also be the issue of limited financial resources. Additionally, there is the question of how much leverage the therapist can maintain to strengthen patient compliance. It is our experience that without leverage, treatment is likely to fail. It is like teaching a lesson of "choices and consequences," one that is rarely a part of such patients' early interpersonal building blocks.

CONCLUSION

Against the background of the growing importance of pathological narcissism, it is remarkable that there are no empirical studies concerning the identification of effective treatments for people suffering from this debilitating disorder. Perhaps such a void is understandable. Doing research with people whose hallmark trait consists of not wanting to follow the same rules as everyone else is unquestionably not an effortless undertaking. Furthermore, there must be an adequate supply of therapists who are confident in their competence in treating NPD (Dieckmann & Behary, 2010). Nonetheless, schema therapy offers a thoughtful and exciting contribution to the collection of treatment models for NPD. We look forward, with great enthusiasm, to gathering more verified evidence of what we have come to observe, appreciate, and celebrate in our clinical experience thus far.

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COGNITIVE BEHAVIORAL PERSPECTIVES ON THE THEORY AND TREATMENT OF THE NARCISSISTIC CHARACTER

ARTHUR FREEMAN AND SUZY FOX

According to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000), the individual with narcissistic personality disorder (NPD) *suffers* from a “pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation of others” (p. 689; italics added). Whether the individual actually “suffers” depends on how the narcissism is perceived and responded to by others and how it is perceived and used by the individual. The pattern of grandiosity occurs whether or not an objectively accurate evaluation of talent, accomplishment, physical prowess, intelligence, competence, physical attractiveness, sense of humor, or creativity is made. If the self-assessment is reinforced by others, the narcissistic individual has reason to maintain and support this self-view. Narcissistic individuals often seem unable or unwilling to see the impacts of their actions on others when those impacts are negative. Their view of the cognitive triad (i.e., how they view the self, the world, and the future) is colored by their self-referent schema.

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Understanding and Treating Pathological Narcissism, J. S. Ogdorniczuk (Editor)

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Furthermore, they may seem to have a poor understanding of self and of their motives. Their sense of self can be easily threatened, and they may be willing to go through sometimes painful experiences rather than be less than the special person that they believe themselves to be and that they expect or demand others to see in them. Their "suffering" comes when their self-view is not accepted or supported by those around them, when they collect the approbation of others, or when they experience a loss of narcissistic pleasures or tributes. In most cases, the negative response of others is often a mystery; narcissistic individuals have difficulty understanding why others do not subscribe to the view they have of themselves.

Narcissism ranges from mild to severe. A mild form may be interpreted as high self-esteem and may be seen by parents and teachers as a positive aspect of the child's personality. The moderate to severe manifestations are less easily excused or seen as positive. Another available lens through which to view narcissistic behavior is on the altruist–narcissist spectrum. At one end would be the altruist, whose major concern would be for others, even if that entails a loss of personal safety, recognition, or profit. On the other end, the narcissistic individual evidences a greater self-concern with a concomitant lack of caring or empathy for others. Rather than fall into the diagnostic dichotomy of narcissism, the clinician must recognize that the only place one can find a "pure" narcissist is in the pages of DSM–IV–TR (American Psychiatric Association, 2000). The clinical presentations generally include Axis I disorders (depression and anxiety) as well as Axis II, Cluster B combinations of narcissistic/histrionic, narcissistic/antisocial, and narcissistic/borderline disorders.

Federn (1952) differentiated between healthy and pathological narcissism. Healthy narcissism contributes to hope and ambition, motivating the individual to grow and to be creative. Pathological narcissism serves as a substitute for hope and ambition. In healthy narcissism, the boundaries of the ego are firm and resilient. In pathological narcissism, ego boundaries are unstable. The fantasies of the normal or healthy narcissistic individual, on both the conscious and unconscious levels, are more in accord with reality and are less infantile. The grandiose and magical elements that are the hallmark of narcissistic fantasies are related to how far the narcissistic style differs from the normal and the acceptance by the individual of certain schema.

Horney (1937) also differentiated between healthy strivings for power and neurotic strivings:

The feeling of power, for example, may, in a normal person be born of the realization of his own superior strength, whether it be physical strength or ability, mental capacities, or maturity of wisdom. Or his striving for power may be connected with some particular cause; family, political, or

professional group, native land, a religious or scientific idea. The neurotic striving for power, however, is born out of anxiety, hatred and feelings of inferiority. To put it categorically, the normal striving for power is born of strength, the neurotic of weakness. (p. 163)

Horney saw the narcissistic striving and the resultant behavior as being expressions of weakness and deprivation for which the self-glorifying and self-righteousness of the narcissistic individual are not functions of self-love, but rather self-hate. The narcissistic style

has nothing to do with any kind of self-love; it does not even contain any element of complacency or conceit, because contrary to appearances, there is never a real conviction of being right, but only a constant desperate need to appear justified. (p. 210)

Narcissistic individuals who are highly intelligent may, in fact, have good impulse control and social functioning with the capacity for active and consistent work, which may allow them to achieve success. They “can be found as leaders in industrial organizations or academic institutions; they may also be outstanding performers in some artistic domain” (Kernberg, 1975, p. 229). Researchers in the areas of industrial–organizational psychology and leadership have found evidence that certain occupational roles requiring or rewarding a confident social presentation, persuasiveness, authoritative-ness, nonconventional creativity, and certain styles of leadership favor certain types of narcissistic individuals. With their unusually high expectations of themselves (task-specific self-efficacy), preferences for challenging goals (need for achievement), beliefs in their personal control (internal locus of control), and self-serving assertiveness in organizational politics, many narcissistic individuals rise to positions of leadership in their work organizations (Hill & Yousey, 1998; Lubit, 2002; Rosenthal & Pittinsky, 2006). This form of narcissism can arguably be considered “adaptive” as long as the individuals continue to receive and perceive “evidence” of their importance and success. Their difficulty will surface when they no longer have the accoutrement and trappings of recognition, success, and the perceived appreciation of others.

In discussing the etiology of a narcissistic personality, Millon and Everly (1985) and Millon, Millon, Meagher, and Grossman (2004) described three factors in the development of a narcissistic style: parental indulgence and overevaluation, learned exploitative behavior, and only-child status. These “learnings” are coded as rules or schema that direct the individual’s behavior and serve as filters for receptive and expressive data. In terms of parental indulgence, the parents view the child as special and perhaps even better than siblings or relatives. These children draw several conclusions from this parental view: (a) that they deserve to be treated with distinction and do not have to

earn such treatment; (b) that they are special, superior people; (c) that they can expect compliance and even subservience from other not-so-special people; (d) that they can expect commendation and praise for virtually everything they do; and (e) that the world revolves around their whims and wishes. They are egotistical in their perspectives and narcissistic in their expressions of love and emotion (Millon & Everly, 1985, pp. 75–76).

As these individuals move outside the favored position within the family, they expect to be treated in ways similar to those to which they had become accustomed. They quickly learn to manipulate others and situations so as to receive the special status that they have learned that they should get, regardless of their performance or ability. They learn the “buttons” and idiosyncrasies of others and use this information to manipulate and exploit others in order to get the recognition that they believe that they deserve. “Exploitation of others seems to be powerfully reinforcing and, therefore, difficult to bring to extinction” (Millon & Everly, 1985, p. 77).

Hamner and Turner (1985) made three assumptions about the development of self-concept: that it is learned, that this learning occurs early in the socialization process, and that the self-concept is a powerful determinant of behavior. This view implies that inappropriate early socialization could result in the individual’s learning an unrealistically high appraisal of his or her capabilities and for developing a pathological level of narcissism, but it does not specify the type of socialization that would produce this problem.

Theories regarding the development of the self-concept provide another perspective on narcissism. During normal development, a major part of the parental role is to help a child develop a positive self-image and a strong sense of self-concept or self-esteem (Hamner & Turner, 1985). These schemas would ideally translate into a sense of personal efficacy, a feeling of satisfaction that is derived from successfully dealing with stressors and limitations imposed by one’s environment. This may lead to what we might term *healthy narcissism*, that is, a positive sense of self that is developed by having an awareness and acceptance of one’s abilities and limitations and a striving to further develop one’s abilities without the need to flaunt one’s accomplishments.

Narcissistic individuals often go to considerable lengths to maintain their high opinion of themselves. Maintaining physical health may take an exaggerated form (e.g., fad dieting; working out to maintain the illusion of strength, health, or beauty). They may seek and use reconstructive surgery to “correct” physical flaws to the point of body dysmorphia. The need for the individual’s academic success may result in a joyless school experience that centers on grades and recognition rather than on learning or enjoying the learning process. This may be strongly reinforced by family, peers, and teachers. Similarly, the narcissistic individual’s need for professional success and recognition may result in a career strongly focused on the acquisition of status and

selected for recall or what is “suppressed”), cognition (the abstraction and interpretation of information), affect (the generation of feelings), motivation (wishes and desires), and action and control (self-monitoring, inhibition, or direction of action; Beck, Freeman, & Associates, 1990; Beck et al., 2004). By this selectivity, the schemata allow for more efficient information processing (Mandler, 1984; Taylor & Crocker, 1981).

Schemata are not isolated; they are interlocking and appear in various constellations. For example, although most individuals in Western cultures have learned and would subscribe to the basic personal/religious/cultural schema “Thou shalt not steal,” they might still take something belonging to another individual. The rationale of the narcissistic individual might be based on other parallel “rules” such as “I deserve it,” “It is due to me,” or “If anyone has something that I do not have it is intolerable for me.”

Through the use of selective abstraction, these individuals overattend to schema-consistent information and underattend to information inconsistent with those assumptions. It is an instance of confirmatory bias in information processing. Narcissistic individuals continually seek information consistent with their positive (or grandiose) views of self, world, and future, and do not seek, perceive, or see as valid, information that contrasts with or contradicts this view.

Overgeneralization involves applying conclusions appropriate to a specific instance to an entire class of experience based on perceived similarities and is an instance of global reasoning. Having been successful at one task (no matter how circumscribed or limited), narcissistic individuals conclude that they will be successful or superior at all similar tasks.

Magnification and minimization occur when the person over-attends to and exaggerates the importance of aspects of experience and discounts or underestimates the relevance of negative or nonconfirmatory experience.

Narcissistic persons are more likely to inaccurately interpret situations when their self-worth is on the line. Thus, when an event is most in need of critical analysis, the person may be less likely to accommodate and more likely to attempt to assimilate the new situation into the existing repertoire of knowledge and responses. In the best of circumstances, this has adaptive purposes: A quick assessment of a strange situation, using old knowledge, may save one’s life. Unfortunately, it becomes problematic when the assessment discounts essential information that would call for a different response

THE NARCISSISTIC FAMILY

Based on Freeman and Rigby (2003), we can identify several family and systemic conditions that contribute to the development of a narcissistic schema:

1. Parents fail to teach the child frustration tolerance.
2. The child is not taught the meaning and importance of boundaries and limits.
3. Overly permissive parents do not impose consequences for inappropriate behavior.
4. A skewed parental value system awards the child as special.
5. The parental style of manifesting self-esteem is often reflected by the child. If a parent is narcissistic, he or she models certain behaviors and a general style for the child.
6. Parental neglect and/or rejection leads to narcissistic over-compensation.
7. An only child or only grandchild is rewarded for little achievement.
8. Parents act out their frustrations at never having been able to achieve the goals that they (or their parents) had for them and that they get vicariously through the child.
9. Parents are unskilled in child rearing and agree to every request or demand made by the child.
10. Systems reward every behavior as special, whether or not the award is earned (e.g., all children get a trophy to avoid injuring the child's fragile "ego").

TREATMENT ISSUES

The clinician must think in terms of the individual's temperament, which represents the genetic contribution (genotype) to development and behavioral style. Is narcissism a genetic predisposition designed for survival? The alpha animal gets more food, the choice food and bed, choice of mates, control over others, and death or banishment of adversaries; does this position imply narcissism? The observable behavior and physical appearance are together labeled as the phenotype. It is this level that is observed and used as grist for the diagnostic mill. The cultural, family, and environmental context within which the child develops can be thought of as the sociotype. There are several cultures that view their own culture or ethnic group as superior and therefore have rights and dominion over other "lesser" groups of people; the results of such beliefs include the Holocaust, slavery, and prejudice. The interplay of these elements makes for the colors and shading of the disorder.

Several questions are raised regarding the treatment of the narcissistic individual. First, what brings the individual into therapy? A second and probably more important question is, what keeps the individual in treatment? Third, what are the goals of therapy? Fourth, who is involved in the therapy?