

## Two Subtypes of Narcissistic Personality Disorder

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*Abstract:* The spectrum of narcissistic disturbances described in the psychoanalytic literature is not reflected in the rather narrow criteria of the third revised edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, American Psychiatric Association, 1987). Narcissistic personality disorder can be conceptualized as occurring on a continuum between two extremes. At one end of the continuum is the *oblivious* subtype, and on the other end is the *hypervigilant* subtype. These two entities may be distinguished by characteristic transference and countertransference patterns. (*Bulletin of the Menninger Clinic*, 53, 527-532)

Readers of the psychoanalytic literature cannot fail to notice that patients across a broad spectrum are referred to as suffering from narcissistic personality disorder. Unfortunately, the nine diagnostic criteria selected by the collaborators on the third revised edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R)*, American Psychiatric Association, 1987) are too narrowly drawn to capture the diverse nature of patients with this characterological diagnosis (see Table 1). These criteria identify a *certain kind* of narcissistic patient, specifically, the arrogant, boastful, "noisy" individual who demands to be in the spotlight. However, they fail to characterize the shy, quietly

grandiose, narcissistic individual whose extreme sensitivity to slights leads to an assiduous avoidance of the spotlight (Cooper & Michels, 1988).

The literature identifies something of a continuum of narcissistic personality disorder. Kernberg (1970, 1974a, 1974b) identified an envious, greedy type who demands the attention and acclaim of others, while Kohut (1971, 1977, 1984) described a narcissistically vulnerable type who is prone to self-fragmentation. Bursten (1973) divided narcissistic patients into four groups: "the craving, the paranoid, the manipulative, and the phallic narcissistic" (p. 290). The various descriptions of narcissistic patients described by these

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**Table 1**  
**DSM-III-R Criteria for Narcissistic Personality Disorder**

A pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least *five* of the following:

1. Reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed)
2. Is interpersonally exploitative: takes advantage of others to achieve his or her own ends
3. Has a grandiose sense of self-importance, e.g., exaggerates achievements and talents, expects to be noticed as "special" without appropriate achievement
4. Believes that his or her problems are unique and can be understood only by other special people
5. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
6. Has a sense of entitlement: unreasonable expectation of especially favorable treatment, e.g., assumes that he or she does not have to wait in line when others must do so
7. Requires constant attention and admiration, e.g., keeps fishing for compliments
8. Lack of empathy: inability to recognize and experience how others feel, e.g., annoyance and surprise when a friend who is seriously ill cancels a date
9. Is preoccupied with feelings of envy

(from *DSM-III-R*, 1987, p. 351)

authors may be conceptualized as falling between two poles on a continuum based on the typical style of interpersonal relatedness. From a descriptive standpoint, the two opposite extremes on this continuum may be labeled the *oblivious* narcissist and the *hypervigilant* narcissist (see Table 2). These terms specifically refer to the person's predominant style of interacting, both in transference relationships with a therapist and in social relationships in general.

Oblivious types appear to have no awareness whatsoever of their impact on others. They can often be observed in action at cocktail parties or in other social situations. They talk as though addressing a large audience, rarely establishing eye contact and generally looking over the

heads of those around them. They talk "at" others, not "to" them. They are oblivious to the fact that they are boring and that some people will therefore leave the conversation and seek companionship elsewhere. Their talk is replete with references to their own accomplishments, and they clearly need to be the center of attention. They are insensitive to the needs of others, even to the point that they do not allow others to contribute to the conversation. They are often perceived as "having a sender but no receiver." The oblivious type is closely related to the *DSM-III-R* criteria, but is much more impervious to criticism than those criteria imply.

The narcissistic issues of the hypervigilant type, on the other hand, are man-



Table 2

## Two Subtypes of Narcissistic Personality Disorder

The Oblivious Narcissist	The Hypervigilant Narcissist
1. Has no awareness of reactions of others	1. Is highly sensitive to reactions of others
2. Is arrogant and aggressive	2. Is inhibited, shy, or even self-effacing
3. Is self-absorbed	3. Directs attention more toward others than toward self
4. Needs to be the center of attention	4. Shuns being the center of attention
5. Has a "sender but no receiver"	5. Listens to others carefully for evidence of slights or criticisms
6. Is apparently impervious to hurt feelings of others	6. Has easily hurt feelings; is prone to feeling ashamed or humiliated

ifested in starkly different ways. These people are exquisitely sensitive to how others react to them. In fact, their attention is continually directed toward others, in contrast to the self-absorption of the oblivious narcissist. Like the paranoid patient, they listen to others carefully for evidence of any critical reaction, and they tend to feel slighted at every turn. These patients are shy and inhibited to the point of being self-effacing. They shun the limelight because they are convinced that they will be rejected and humiliated. At the core of their inner world is a deep sense of shame related to their secret wish to exhibit themselves in a grandiose manner.

Although both types struggle with maintaining self-esteem, they deal with that issue in extremely different ways. Oblivious narcissists attempt to impress others with their accomplishments while insulating themselves from narcissistic injury by filtering out the responses of others. Hypervigilant narcissists attempt to maintain their self-esteem by avoiding vulnerable situations and by intensely studying others to "figure out" how to behave. They projectively attribute their own disapproval of their grandiose fantasies onto others (Gabbard, 1983).

## Countertransference Patterns

In keeping with the foregoing descriptions, each type may be readily identified by transference developments with a therapist or analyst. Similarly, each type also evokes characteristic patterns of countertransference in the therapist or analyst.

*The Oblivious Patient*

The oblivious patient forces therapists to tolerate a "satellite existence" (Kernberg, 1974b, p. 220) in which they are apt to feel that the patient is unaware of their presence in the room. Countertransference feelings of boredom and irritation are common with these patients. For prolonged periods, the therapist may have to tolerate a sense of being used as a sounding board by the patient. Oblivious narcissistic patients hold forth in the office as though they were speaking in a crowded amphitheater, ignoring the therapist as a separate person with separate thoughts and feelings.

*Case Example*

Mr. U came to therapy after three previously failed attempts. His latest treat-

ment had lasted 3 years with a therapist in another city. Mr. U denigrated that therapeutic experience as "a complete waste of time" and could not even recall the therapist's name.\* He said that "doctor what's-his-name" interrupted him a lot and was not a good listener. Mr. U talked at great length about his need for a really "special" therapist. He even speculated that there might not be anyone in the city who could really understand him.

As Mr. U continued to ramble at some length over many weeks, his therapist began to dread each session. The therapist found his thoughts wandering to his plans for the evening, his financial status, unfinished paperwork, and a variety of other matters with little bearing on Mr. U and his problems. The therapist also found himself glancing at the clock more often than usual, eagerly awaiting the end of Mr. U's session. When the therapist intervened, Mr. U would often ignore his comments and say, "Just let me finish this train of thought first," or "Oh, yes, I'm already aware of that."

After returning from a 3-week vacation, the therapist resumed his sessions with Mr. U. In the first session, the patient picked up where he had left off at the end of the previous session, as though no time had elapsed. The therapist, exasperated with the sense that he had no importance whatsoever to Mr. U, said, "You act as though we saw each other yesterday. Didn't the 3-week separation from me have any impact on you?" Mr. U detected a critical, sarcastic tone in the therapist's voice and replied, "You have the same problem as my last therapist. You're always inserting yourself into this. I'm not paying you to talk about you or your feel-

ings. I'm here to talk about myself." All of us in the mental health professions have a need to be needed, and the oblivious patient challenges that fundamental psychological dimension in all therapists.

### *The Hypervigilant Patient*

The hypervigilant variety of narcissistic personality leads the therapist to struggle with different countertransference problems. Every shifting of weight by the therapist, every clearing of the throat, every glance at the clock is perceived as a slight. Therapists are apt to feel coerced into sitting still and into focusing unwavering attention on the patient. In addition to this feeling of being controlled, there is also a countertransference resentment of being falsely accused of neglect and inattention.

### *Case Example*

Ms. V came to psychotherapy after a devastating rejection by her boyfriend. She was convinced that it was only a matter of time until her male therapist would also grow disenchanted with her. When his stomach growled during one session, she immediately responded, "Well, it's clear that your mind is already on lunch. Don't worry, I'll be out of here in 10 minutes." If the therapist was silent, Ms. V would ask if she was boring him. If he spoke, the patient would misperceive the gentlest clarification or inquiry as a devastating narcissistic injury. During one session, the therapist reached down to pick up a piece of mud on the carpet to toss it in the wastebasket. Ms. V became enraged and shouted at her therapist, "If I'm no more

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\* These two signs—an inability to remember a previous therapist's name and a complete devaluation of the previous therapeutic experience—are often diagnostic clues to narcissistic character pathology.



important than mud on your carpet, then I'm going to find me a new therapist!" Her therapist, feeling chronically misunderstood by Ms. V, was surprised by his strong wish that she would follow through on her threat.

### Discussion

These two types of narcissistic personality disorder may occur in pure form, but many patients come to treatment with a mixture of phenomenological features from both types. Between these two endpoints on the continuum will be many narcissistic individuals who are much smoother socially and who possess a great deal of interpersonal charm.

These distinctions may well relate to the controversy in the literature regarding Kohut's views (1971, 1977, 1984) and those of Kernberg (1970, 1974a, 1974b, 1984). Adler (1986) suggested that these authors may actually be describing different subgroups of narcissistic patients. Kohut described relatively well-functioning professionals who are vulnerable to slights in the work place and in interpersonal relationships. These patients are more closely related to the hypervigilant end of the continuum. On the other hand, Kernberg's patients appear to be more primitive, more aggressive, and more arrogant than Kohut's and are more closely allied with the oblivious end of the spectrum.

Although detailed formulations about psychodynamics and treatment implications are beyond the scope of this brief communication, these subtypes alert the clinician to a fundamental pitfall in the treatment of narcissistic patients. Psychotherapists faced with the formidable task of treating these patients must avoid the arbitrary application of one particular theoretical framework to a given patient. Therapists must listen carefully to their

patients, observe the transference and countertransference developments, and particularly note their responses to trial interventions. In this manner, therapists will soon reach a tentative conclusion about which theoretical and technical model is the most helpful to a particular patient.

Hypervigilant patients will often not tolerate anything but an empathic, experience-near approach based on Kohut's model. Because they possess a fragile self prone to fragmentation, any deviation from empathic attunement may be met with prolonged "shutdowns" in response to perceived narcissistic injury. By contrast, oblivious patients protect themselves with a heavily armored self that can be penetrated only by forceful confrontations and interpretations of envy and contempt, similar to the technical recommendations of Kernberg. Still other patients can benefit from a combination of technical strategies. As in all psychotherapy, the treatment must be adjusted to the patient, not the patient to the treatment.

### References

- Adler, G. (1986). Psychotherapy of the narcissistic personality disorder patient: Two contrasting approaches. *American Journal of Psychiatry*, 143, 430-436.
- American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.). Washington, DC: Author.
- Bursten, B. (1973). Some narcissistic personality types. *International Journal of Psycho-Analysis*, 54, 287-300.
- Cooper, A. M., & Michels, R. (1988). [Review of *Diagnostic and statistical manual of mental disorders* (3rd ed., rev.)]. *American Journal of Psychiatry*, 145, 1300-1301.
- Gabbard, G. O. (1983). Further contributions to the understanding of stage fright: Narcis-

- sistic issues. *Journal of the American Psychoanalytic Association*, 31, 423-441.
- Kernberg, O. F. (1970). Factors in the psychoanalytic treatment of narcissistic personalities. *Journal of the American Psychoanalytic Association*, 18, 51-85.
- Kernberg, O. F. (1974a). Contrasting viewpoints regarding the nature and psychoanalytic treatment of narcissistic personalities: A preliminary communication. *Journal of the American Psychoanalytic Association*, 22, 255-267.
- Kernberg, O. F. (1974b). Further contributions to the treatment of narcissistic personalities. *International Journal of Psycho-Analysis*, 55, 215-240.
- Kernberg, O. F. (1984). *Severe personality disorders: Psychotherapeutic strategies*. New Haven, CT: Yale University Press.
- Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorders*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Kohut, H. (1984). *How does analysis cure?* (A. Goldberg, Ed.). Chicago: University of Chicago Press.