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MALIGNANT NARCISSISM: FROM FAIRY TALES TO HARSH REALITY

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SUMMARY

Introduction*: Malignant Narcissism has been recognized as a serious condition but it has been largely ignored in psychiatric literature and research. In order to bring this subject to the attention of mental health professionals, this paper presents a contemporary synthesis of the biopsychosocial dynamics and recommendations for treatment of Malignant Narcissism.*

Methods*: We reviewed the literature on Malignant Narcissism which was sparse. It was first described in psychiatry by Otto Kernberg in 1984. There have been few contributions to the literature since that time. We discovered that the syndrome of Malignant Narcissism was expressed in fairy tales as a part of the collective unconscious long before it was recognized by psychiatry. We searched for prominent malignant narcissists in recent history. We reviewed the literature on treatment and developed categories for family assessment.*

Results*: Malignant Narcissism is described as a core Narcissistic personality disorder, antisocial behavior, ego-syntonic sadism, and a paranoid orientation. There is no structured interview or self-report measure that identifies Malignant Narcissism and this interferes with research, clinical diagnosis and treatment. This paper presents a synthesis of current knowledge about Malignant Narcissism and proposes a foundation for treatment.*

Conclusions*: Malignant Narcissism is a severe personality disorder that has devastating consequences for the family and society. It requires attention within the discipline of psychiatry and the social science community. We recommend treatment in a therapeutic community and a program of prevention that is focused on psychoeducation, not only in mental health professionals, but in the wider social community.*

Key words: *Malignant Narcissism - personality disorders - therapeutic community*

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INTRODUCTION

Fairy tales allow parents to help children prepare for the realities of life. Although we imagine leaving fantasy behind as we grow up, we continue to mix fantasy with reality throughout life and often deny reason to hold onto our fantasies (Bettleheim 1981).

Fairy tales arise from folk traditions. Things that are too dangerous to accept consciously are repressed and reappear in dreams and fairy tales. Fairy tales take place in a transitional space between fantasy/magic and reality. The dangerous becomes less frightening in fairy tales where good always triumphs over evil (Bettleheim 1981).

As youth we are inducted into society by finding ourselves reflected in folk images. Initially, we live in a world saturated with elementary folk images, and later, we encounter the elementary ideas themselves. Jung described these elementary ideas as archetypes. We must struggle over time with life experiences that put us in touch with good and evil and if development is to be successful, then, metaphorically, the serpent that represents the struggle between life and death has to bite us strongly enough to awaken us to an internal world of transcendence. We need to die in the world of the ego to transcend ourselves. However, not everyone can master this and not every elemental idea is transcended by society (Campbell 1981).

In the fairy tales of Snow White and Cinderella an evil stepmother is presented who humiliates and tries to psychologically and physically kill an innocent stepchild. She is presented as an aloof, arrogant, cold, person with high social status and power who is preoccupied with external beauty and the need to impress others. She has no remorse for her evil actions. She is loyal to her biological children whom she treats with entitlement and projects all her hatred and anger onto her stepchildren. The world is divided into that which is hers, which is perfect, and that which is not hers, which includes bad objects she believes should be humiliated and destroyed. The father figure is frequently absent or passive in fairy tales. He is 'handicapped' in his relationship with the stepmother because he has a child. The cruel woman is not his first choice, but she is beautiful and powerful. He may be attracted to this image because he feels inadequate for loosing his first wife and wants to be seen as a success. His primary interest is not in protecting his child. In the end of the fairy tales, the evil stepmother is banished and disappears into the void. She is never punished or asked to redeem herself. The evil stepmother portrays a classical malignant narcissist (Moore & Goldner-Vukov 2004).

THE PERSONALITY DISORDER OF MALIGNANT NARCISSISM

The social psychologist Erich Fromm first used the term "malignant narcissism" (MN) in 1964 describing it as a severe mental disorder. He called MN "the quintessence of evil" (Fromm 1964).

Kernberg (1984) introduced the concept of MN to psychoanalytic literature in 1984. Very little has been written about MN since his contribution. Kernberg outlined four features of this syndrome: 1) a typical core narcissistic personality disorder (NPD), 2) antisocial behaviour (ASB), 3) ego-syntonic sadism and 4) a deeply paranoid orientation toward life (Kernberg 1984).

Narcissistic personality disorder

The core features of NPD that are recognized in MN are a grandiose sense of self-importance, preoccupation with fantasies of unlimited success, power and brilliance, a belief in being special or unique, a strong need for excessive admiration, a sense of entitlement, interpersonal exploitativeness, a lack of empathy and prominent envy (APA 2000).

In MN destructive aspects of the self and the expression of aggression become idealized (Rosenfield, 1971). People with MN give the appearance of being self-sufficient and successful. Covertly, however, they are fragile, vulnerable to shame and sensitive to criticism. Failure to succeed in grandiose efforts results in prominent mood swings with irritability, rage and feelings of emptiness. People with MN are driven by an intense need for recognition. Inwardly, they are deeply envious of people who have meaningful lives. They are adaptive, capable of consistent hard work and of achieving success. However, their work is done primarily to gain admiration and their intellect is strikingly shallow. They are often materialistic and ready to shift their values to gain favour. They are prone to pathological lying. In the realm of love and sexuality they are charming, seductive and promiscuous, but unable to develop deep relationships. When not involved in narcissistic pursuits, they are cold, unempathetic, exploitative and indifferent towards others. Disturbing feelings of inferiority, self-doubt, boredom, alienation, emptiness and aimlessness underlie their persona (Kernberg 1984).

MN is situated between NPD and Antisocial personality disorder (ASP) and is separated from the later by the capacity for selected loyalties. Malignant narcissism can be differentiated from ASP by the capacity of the malignant narcissist to internalize both aggressive and sadistic features of the pathological grandiose self. People with ASP have a paranoid stance against external influences that makes them unwilling to internalize even the values of aggression. Malignant Narcissists develop identification with powerful people and rely on internal sadistic and powerful parental images (Kernberg 1992).

Antisocial Features

Their antisocial behaviour does not meet DSM IV criteria for Antisocial personality disorder (ASP). They are contemptuous of social conventions and show a passive tendency to lie, steal, and mismanage money. They may commit burglary, assault or murder and they may even become leaders of sadistic or terrorist groups. They are capable of feeling concern and loyalty for others (Kernberg 1992), but primarily for their disciples or blind followers. They realize that others have moral concerns, but they easily rationalize their antisocial behaviour. They are adept at avoiding detection (Kernberg 1992, Gunderson & Ronningham 2001).

Ego-Syntonic Sadism

The ego-syntonic sadism of MN is displayed by a characterologically-anchored aggression. It is expressed in a conscious 'ideology' of aggressive self-affirmation. Individuals with MN have a tendency to destroy, symbolically castrate, and dehumanise others. Their rage is fuelled by the desire for revenge. They may present with chronic, ego-syntonic suicidal tendencies but this rarely reflects depression. They become suicidal during crises and when, as masters of their own fate, they see suicide as something triumphant (Kernberg 1992).

Paranoid Features

Kernberg (1975) believes the paranoid orientation of MN may be the basic cause of their self-inflation. The paranoid tendencies in malignant narcissists reflect their projection of unresolved hatred onto others whom they persecute. They have a deep sense of mistrust and view others as enemies/fools or idols, either devaluing or idealizing them. They have disorganised superegos and consequently lack the capacity for remorse, sadness or self-exploration. They are preoccupied with conspiracy theories. Their pathological grandiosity is a defense against paranoid anxiety. Paranoid regression in therapy can lead to episodes of psychosis (Kernberg 1975).

ETIOLOGICAL FACTORS

Possible etiological factors in the development of MN include biological, environmental, psychological and sociocultural factors that contribute to the different features of MN. Narcissistic personality disorder is more common among men than women. Approximately 1% of the general population have been found to have NPD. Antisocial personality disorder has a lifetime prevalence of 3.5% of the population and males are 7 times more likely to have this condition (Yudofsky 2005). The prevalence of MN is unknown. After working for many years in a therapeutic community with people from severely damaged families, the prevalence of MN in consecutive sample of 100 residents was 20% (Moore & Goldner-Vukov 2005). It

is suspected that there are various presentations of MN as is found with many personality disorders and that the aggregated prevalence of this disorder is more common than is generally recognized.

The genetic variance in personality traits in general is 65%, while 10% is felt to be due to shared environmental factors and 25% to non-shared environmental factors including differential parenting (Reddy 2002).

BIOLOGICAL FACTORS

Biological factors include temperament, genetic influences, and the neurobiological consequences of early relational trauma. Brain changes from early relational trauma are more prominent in the development of NPD than other biological factors. Narcissistic personality disorder runs in families but this does not mean there is genetic transmission. Being raised as a child of a parent with NPD could lead to the development of NPD through early relational trauma. Depression can be found as a coexisting disorder with NPD. Depression may be genetically caused and this may result in the development of narcissistic features to overcompensate for poor self-esteem as part of the depression. In addition, brain dysfunction may lead a child to misinterpret parental behavior and experience apparently normal parenting as neglect (Yudofsky 2005).

There is more research on biological factors in the development of ASP. There is strong evidence of a prominent genetic component in ASP. If one monozygotic twin has a criminal background, there is a 66% chance the other will also have criminal behavior. The concordance in dizygotic twins is 31%. Environmental factors have significantly more influence on the development of ASP in juveniles that on adults. For adults, genetic influences are much stronger (Yudofsky 2005).

People with ASP are biologically distinct in several biological areas. They have reduced CNS, peripheral nervous system and endocrine responses to stress, particularly to the danger or threat of personal harm. They have reduced physiological and autonomic arousal with lower resting heart rate, diminished skin conductance responses during rest and more theta waves on electroencephalograms. Functional brain imaging in people with ASP shows abnormalities in the limbic and hippocampal areas and reduced activity in the frontal and temporal lobes. Morality and social conscience are functions of the frontal and temporal lobes which also regulate judgment, abstraction, social skills and executive functions including planning and problem solving skills. Functional brain imaging has shown that the regulation of empathic behavior is located in the left lateral inferior frontal gyrus. Lesions in the right orbitofrontal region reduce impulse control, impair judgment and contribute to sociopathic behavior. Neurotransmitter changes seen in ASP include elevated levels of the male hormone dehydroepiandrosterone, reduction of the serotonin metabolite 5-hydroxyindoleacetic acid and reduction of the dopamine metabolite homovanillic acid (Yudofsky 2005).

Paranoid symptoms can occur when the brain is compromised by medical and psychiatric illnesses. The left temporal and right parietal lobes are involved in paranoia. The hereditary and genetic influences of paranoid features are unknown but when the enzyme beta-hydroxylase which metabolizes dopamine is low, this leads to an increase in dopamine and paranoid psychosis. It is possible that the psychological defense of paranoid projection is biologically based (Yudofsky 2005).

Temperament

Temperament is defined as the automatic, associative responses to basic emotional stimuli that determine habits and skills (Cloninger et al. 1993). Temperament is moderately heritable and stable throughout life (Cloninger et al. 1985) and shapes adaptability, the degree of aggression, affective responses to frustrations and preferred sensory modalities for soothing (Akhtar 1992). Temperament accounts for 50% of personality (Cloninger et al. 1993). Temperament alters the style of attachment (Akhtar 1992).

It is possible to classify individuals into temperament types based on novelty seeking, harm avoidance, and reward dependence (Cloninger et al. 1993). ASP is associated with high novelty seeking, low harm avoidance and low reward dependence. People with ASP seek thrills and danger, and show impulsive, aggressive outwardly directed anger. NPD is associated with high novelty seeking and high reward dependence. People with NPD are excitable, quick-tempered, extravagant, attention seeking, self-indulgent, passionate, insecurely vain, imaginative and ambitious (Cloninger et al. 1993, Akhtar 1992). In MN there is a combination of the temperament of NPD and ASP.

Neurocognitive Disturbances

People with personality disorders suffer from subtle neurocognitive disturbances. They have poor cognitive performance and have problems with executive function, learning, abstract thinking and attention. PET scans show that people with aggression have decreased metabolism in frontal and temporal lobes (O'Leary & Cowdry 1994). Neurocognitive disturbances can be caused by inheritance or developmental trauma.

ENVIRONMENTAL/PSYCHOLOGICAL FACTORS

In the etiology of MN it is important to take into consideration early and late relational trauma. Early relational trauma appears during the first two years of life and it is strongly connected to a child's relationship with primary objects. Less than 'good enough paren-

ting' (Winnicott 1960) and problems with attachment are pivotal in the evolution of Cluster B personality disorders (Torgensen 1994). In the development of MN there is a strong possibility that parents lack the capacity for empathy, the ability to contain infantile rage and the ability to adequately respond to a child's grandiose-exhibitionistic mirroring and idealising needs. Parental figures provide for their children's physical needs but neglect their emotional needs. The attitude of parents of children who will develop MN is controlling and sadistic. They demand that their children be tough, tolerate pain, show no emotion and learn to manipulate others. Parental figures are cold and spiteful but over-admiring of their children's talents and charms (Torgensen 1994). There is no verbal memory for early relational trauma but the "damaged core" appears in later personality problems that reflect the early trauma (Akhtar 2009).

Attachment, Mentalisation, Impaired Right Brain Development and Resulting Dynamics

Attachment is the first regulator of emotional experience and arousal. It is believed to have evolved to ensure the protection of infants. It involves visual, sensory and auditory interchange as part of a process in which the right brains of the mother and infant are in constant unconscious communication. The mother co-regulates the infant's developing autonomic nervous system and this process over time leads to the infant developing a self-regulating system (Schore 2001).

An attachment control system has been identified that includes the right orbitofrontal area (which incorporates cognitive information) and communicates with other aspects of the brain through cortical and subcortical connections including the anterior limbic prefrontal network, the anterior cingulate and the amygdala. The right orbitofrontal area with the hypothalamus controls the autonomic and somatic component of emotional states. The right hemisphere is the locus of the emotional self and the unconscious (Schore 2001).

Attachment creates a foundation for mentalisation, the reflective function or process of interpreting actions of the self and others as meaningful (Schore 2001). Mentalisation is a process whereby infants realise that having a mind mediates their experience in the world. Mentalisation is linked to the development of the self and is the core of human social functioning. The establishment of an attachment system takes place in the first two years of life when the right hemisphere is dominant. Attachment alters the experience-dependent development of the right brain. At the end of two years the attachment system is complete. No matter what happens after this, the type of attachment is fixed.

Trauma during the first two years of life damages right orbitofrontal function impairing social and moral behaviour that leads to a lack of empathy, impaired emotional regulation, aggression, problems with recognition of anger, and problems with mentalisation (Schore 2001).

In MN right brain impairment results in a developmental arrest at the stage of the archaic grandiose self (Kohut 1971), reactive rage and aggression (Kohut 1971) and identification with the aggressor (Schore 2001). The grandiose self is a pathological fusion of 1) special aspects of the self, 2) the idealised self-image and 3) the ideal object representation. Chronic envy underlies the grandiose self and rage incites its formation (Kernberg 1975). Introjective identification is used to incorporate desirable aspects of others claimed to belong to the self. Projective identification is used to externalise unacceptable aspects of the self and deposit them into others. Talents and gifts are hypertrophied. Whatever love is offered is destroyed in order to maintain superiority over others. Goodness in others provokes envy and this is defended against by devaluation, control and avoidance (Kernberg 1975).

Coexisting psychiatric disorders

Narcissistic personality disorder is found in 10% of people with other psychiatric disorders including depression, bipolar disorder, alcoholism and other personality disorders such as borderline and antisocial personality disorders. Up to 70% of people with ASP are also diagnosed with alcoholism or substance use disorders at some point in their lives (Yudofsky 2005).

As Kernberg (1984) suggested, people with NPD, ASP and MN have borderline personality disorganization. People with these disorders are vulnerable to regression and suicidal states. The second author worked in prison settings for 10 years where people with MN and ASP were obstructed from using their preferred defense mechanisms. They were often unable to acquire drugs of abuse and were thwarted in their attempts to exploit other people as objects to satisfy their narcissistic needs. In situations like this, these patients presented with borderline dynamics and were frequently acutely suicidal.

Family dynamics

In families that produce children with NPD, parental figures impede the development of mirroring capacities and empathy (Kohut 1977). Parental figures admire children as narcissistic extensions, i.e., children are 'loved' if they succeed in bringing social affirmation to the parents. Families producing children with ASP are self-absorbed, neglectful or cruel and frequently there is drinking, violence, inconsistent rules, and lack of recognition of constructive and empathic behaviour (Akhtar 1992). A low level of maternal care, a high degree of intrusiveness and a denial of psychological autonomy are associated with ASP traits in males. The same factors in paternal care are associated with ASP

traits in females (Reddy 2002). Disruption of the family and parental mental illness are both associated with ASP (Reddy 2002). Families that produce children with Paranoid PD have rigid rules, irrational beliefs, mistrust, hatred toward others, and restricted expression of emotions. They believe being emotional is a weakness (Kauffman 1981).

SOCIAL AND CULTURAL DYNAMICS

Personality traits and disorders are recognised internationally (WHO 1990) but vary according to cultural differences. In Ethiopia and India 1-3% of psychiatric outpatients have PD compared to 32% in Britain (Akhtar 1992). Traditional societies are protective against PD because social networks buffer for psychological risks. Modern societies value autonomy, achievement, external admiration and individualism and they reward narcissism. Family dysfunction is commonly associated with community dysfunction, fragility of social networks and a lack of social norms. Cultural confusion, migration, poverty, crime, secularization, and social change all increase emotional dysregulation, impulsivity, substance abuse and criminality (Paris 1998).

It is appropriate to consider whether or not modern society is contributing to the development of MN. Prominent political, social, religious and cult leaders have been suspected to be Malignant Narcissists (Storr 1996). People with MN are destructive toward their families and people surrounding them. In order for someone with MN to blossom into a figure that becomes destructive to society on a larger scale, a supportive milieu is required. Social and cultural dynamics play a determining role in supporting people with MN (Reich 1970).

Tyrants have been recognized as malignant narcissists who come to power in economic and political situations where they have an opportunity to consolidate their power. They have severe superego deficits that over time lead to a loss of reality testing and erratic, self-destructive behaviors (Glad 2002).

Malignant narcissism in mental health settings

People with MN do not voluntarily come to mental health service to seek help. They are sometimes referred to mental health services by the judicial system, the criminal justice system or children's protective services. Children with a parental figure with MN occasionally come to mental health services by referral from a medical professional, a teacher or some other person of authority who recognizes that the child and family need help.

The children of parental figures with MN may come to treatment as adults. They suffer from multiple psychiatric problems such as addictive disorders, anxiety disorders including PTSD, depression, suicidality and personality disorders. These people were raized in families with parental figure that can be retrospectively recognized as malignant narcissists. Several case presentations help elucidate this.

CASE #1

Karen was an outstanding female athlete who was a national champion and gained international acclaim. She attended a psychiatric assessment at the request of her GP because of problems with anxiety. Although Karen was gifted and successful, she never enjoyed athletics. She hated every competition in which she participated. After every success she appeared defeated and empty. She never believed that she was gifted athlete, despite international recognition. Karen described herself as a talented writer, hairdresser, and painter, although, objectively, her performance in these areas was below average. She was good looking, but, she was unhappy with her appearance and arranged to have facial plastic surgery. Karen was unpredictable and suffered from mood swings. She was occasionally suicidal and she was a problem drinker. She would lie and steal when it was convenient. She was paranoid, seductive, and promiscuous, and had difficulties in interpersonal relationships.

Karen was raised by a passive, anxious insecure mother who loved her but did not protect her from her father. Her father was a man who came from a low socio-economic background and was preoccupied with success. He changed his family name when he was young because he didn't think his name sounded powerful enough. He worked as a manager in a small company and exaggerated his professional abilities and successes. He was obsessed with being famous and respected. He was at times paranoid, always competitive, and had difficulty in interpersonal relationships. He lied and misrepresented himself when it was convenient and he was involved in minor criminal activities. He presented himself as charming when he needed something but he had poor boundaries and this made him intrusive and demanding. He "blossomed" when he discovered that his daughter was gifted for athletic activities. At that time Karen was 7 or 8 years old. Her father admired her for her gift, but he completely denied every other aspect of her existence. She was required to practise athletic activities every minute of her life, go for competitions and, of course, win, earn money and become famous. He used to compete with Karen and told her that he could have been a better athlete than she was if he had wanted that. He spoke about his daughter's success as it were his success. When Karen became famous, he went from being no one to being "Mr. Someone". When he was dissatisfied with Karen's practice or achievement, he sadistically humiliated her in public. He physically abused her between competitions. She often played with bruises on her back and tears in her eyes. The coaches, teachers, and even the public thought that her father was 'mad', but no one did anything to help her. The GP and

Karen had to conceal the psychiatric assessment from her father. Karen refused further treatment. She grew up, disappeared from the sport's scene and lead a life with a lot of problems and suffering.

Comment: Karen's father was a malignant narcissist. He had a core narcissistic personality disorder (NPD). He had a grandiose sense of his own importance and was preoccupied with his fame. He needed a continued source of social admiration and exploited his daughter's life to satisfy his own needs. He was envious of his daughter's gift but lacked any sense of true empathy for her needs. He had antisocial behaviours, was physically abusive Karin. It was obvious even to the public that he was cruel and sadistic and that he persecuted his daughter.

CASE #2

John was a young man in his forties who was treated for paranoid schizophrenia and substance abuse. He was sensitive, intelligent, anxious, depressed and at times suicidal. He was interested in psychology, art and philosophy. He had several jobs, but he disliked them all. He could never establish a relationship with a woman because he was insecure and impotent. He desperately wanted to get a job, get married, raise children and have a decent life. When asked about his family of origin he reported that his father was a famous man, almost a legend in his country.

His father was an obsessive, rich, self-centred, paranoid, and highly competitive man. He was a celebrated national athlete who took great pleasure in being famous. John's father never loved him because John was physically frail and psychologically unstable. Despite this, his father continued to have high expectations of him; he wanted to have a son who would bring him glory. John's father was cruel and humiliating; he physically abused John and went into foul moods where he would stop communicating with him for long periods of time. When John developed a serious mental illness, his father rejected him. He never visited John in the hospital and refused to pay for his medication. His father was involved in real estate deals of questionable integrity. John's mother was a detached, frightened woman who was emotionally abused by her husband. She did everything possible to keep the family secrets in order to protect her husband's fame. After a course of treatment that did not significantly improve John's mental health, he took an overdose and ended his life. His father never bothered to contact the mental health service.

Comment: John's father was a malignant narcissist. He had a core NPD and he treated John like a narcissistic extension of himself. When John was unable to fulfil the expectation of gaining glory for his father, his father devalued him and rejected him. John's father showed antisocial behavior in his business negotiations. He physically abused John and abandoned him when needed his father's love the most. His father was sadistic and projected his unresolved hatred and aggression onto John and tortured him to the point where life no longer had meaning for John.

HISTORICAL FIGURES WITH MALIGNANT NARCISSISM

To investigate the nature of MN and the social consequences for society, the childhood histories of three prominent dictators of the 20th Century were reviewed. Adolf Hitler, Joseph Stalin and Mao Zedong committed crimes that are beyond imagination and at the same time they were creators of the modern world (Miller 1990, Montefiore 2007, Yang & Halliday 2007). What is not so well known about these prominent leaders is the experiences of their childhood and the possible influence of early and late relational trauma in the development of their personalities.

Family Histories

Their family histories had striking similarities. Their mothers lost either 2 or 3 children prior to their births. Their mothers were religious, strict and idolized and 'spoiled' them. They were ruthlessly beaten by their fathers who tried to control them and obstruct their development. They hated their fathers and loved their mother's initially, but later rejected their mothers as well. They had a variety of humiliations in their childhood family life as well as separations with multiple parental figures. Social and environmental factors outside the family also shaped their development. They were unable to maintain normal or faithful relationships with women (Miller 1990, Montefiore 2007, Yang & Halliday 2007)

Malignant Narcissists

All three dictators were malignant narcissists. They had core narcissistic personalities, marked antisocial behaviours, paranoid and sadistic features. They were all loyal to selective associates. Their early childhoods appear to have been disrupted by the unresolved grief of their mothers. Mothers who loose children usually idealize and 'spoil' the next surviving child as a substitute for real love. At the same time mothers can harbour hatred toward the child that survives, especially when this is the only avenue for the expression of their unresolved grief. Children born after deceased siblings are driven to achieve on an extraordinary level in order to gain the attention of their mothers. If these 'spoiled' children had been loved, they would have been able to establish meaningful loving relationships. None of these men were capable of this. They were loved as narcissistic extensions of their parents. The beatings and cruelty they survived probably led to their paranoia and antisocial behaviours. Their sadism was most likely due to harbouring intense feelings of anger, humiliation,

envy and hatred but being unable to express these emotions in any way, driving them to an unconscious level and forcing their expression through projection and displacement (Miller 1990).

Malignant Narcissism has been recognized in Hitler, Stalin and Mao as well as other tyrants by other authors (Glad 2002, Post 1993, Lifton 1968, Pye 1976, Terrill 1980, Li 1994).

TREATMENT

There is little relevant literature to guide the treatment of people with MN and the discussions in this section draw from what is known about the treatment of NPD, ASP, paranoid features and the treatment of personality disorders in general. People with MN are usually prominent people who are high achievers who do not believe they need anyone's help and they probably actively avoid mental health professionals. People around them who make recognize they have problem but most likely afraid to suggest they seek help. Their paranoid features cause them to see other people as bad objects who are either potential threats or enemies. Their sadistic behaviors create tendencies toward humiliation and hatred. They likely to see therapists as bad objects who they would like to dominate and control in order to avoid their fears of being persecuted. This pattern becomes an obsessive mechanism by which they regulate the suppression and repression of aggression (Kernberg 2004).

Malignant narcissists may come to treatment under duress from social services or correctional institutions. They occasionally come to get help for coexisting mental disorders, possibly at the request of partners or family members. It is important to understand the serious coexisting disorders including substance abuse and dependence problems, depression, bipolar disorder, anxiety disorders and especially the presentation of suicidal behaviors in all patients with borderline personality organization (Marcinko & Vuksan-Cusa 2009). Countertransference reactions are especially critical to understand with these patients (Marcinko et al. 2008) and individual, couple and marital therapy is often required in order to achieve therapeutic progress (Marcinko & Bilic 2010).

Treatment will be divided in psychopharmaco-therapy, principles of effective treatment, principles of therapeutic community with adjunctive psychotherapy including individual, modified dialectical behavioral therapy, couple and family therapy.

Principles of Effective Treatment

The principles of effective treatment of MN include requiring patients to accept responsibility for their antisocial and sadistic behaviours, expecting patients to maintain predictable, rational actions and reactions, insisting on the development of consequential thinking, social reinforcement of respectful boundaries and respect for the needs of others, strong confrontation of unjust and capricious behaviours, recognition of manipulation with immediate confrontation, consequences for every transgression, not allowing any abuse to be kept secret and not allowing the use of others as a source of narcissistic supply. Individual therapy could never satisfy these requirements. The most effective treatment for Personality Disorders is a therapeutic community where an intensive holding and corrective environment is part of the foundation of treatment. In the context of a therapeutic community it is possible to include individual psychotherapy including skill building with modified dialectical behavioral therapy, individual, couple, group and family therapy. There may be circumstances in which a therapist feels comfortable treating someone with MN individually.

Principles of Therapeutic Community

A therapeutic community uses a behavioural approach such that behaviour change precedes attitude change. It also uses a developmental approach that allows a period of stabilization and sequential psycho-social changes according to an established hierarchy. The fundamental values of a therapeutic community are concern for others, honesty, love, trust and responsibility. In the therapeutic community the group is the fundamental vehicle for change both in the community environment and in group therapy. Peer pressure breaks down resistance and promotes personal growth. The community also promotes creativity and offers a sense of belonging. The therapeutic community reduces pathological narcissism through corrective achievements, corrective relationships and corrective disillusionment (Ronningstam 1989, Dolan & Coid 1993).

Psychopharmacotherapy

Atypical antipsychotics are the preferred treatment for PD. They improve anger, hostility, irritability, impulsivity and the cognitive-perceptual abnormalities that underlie psychosis seen in Personality Disorders. Selective Serotonin Reuptake Inhibitors (SSRI's) reduce anger, impulsivity, aggression and affective instability. SSRI's act like a brake modulating limbic irritability and hyperarousal as well as improving frontal lobe function and judgement. Lithium, sodium valproate and carbamazepine improve mood, stabilize affect and reduce impulsivity and aggression perhaps by modulating serotonin pathways. Some people respond to SSRI alone, and others do better with a combination of an SSRI and a mood stabiliser. Beta blockers and central norepinephrine blockers help reduce norepine-phrine levels that are shown to be elevated with aggression (Solof 2000, Sievers 2002).

Psychotherapy

Fifty-two percent of people suffering from personality disorders achieve remission in 1.3 years of treatment (Perry & Bond 1999). Effective psychotherapeutic interventions include confrontation (for defensive and regressive transference) supportive, exploratory or expressive therapy and the development of a strong therapeutic alliance (TA) (Gabbard & Twemlo 1994). Obstacles to effective treatment include poor motivation, using defensive 'invincible armour' of power (Clarkin et al. 1999), sadistic injury, superior IQ, lack of remorse and lack of capacity for attachment. Positive prognostic factors include the capacity for loyalty, remnants of genuine concern for others, a sense of remorse, being gifted or talented in some life skills, being attractive and have self discipline (Stone 1989).

Modified Dialectical Behavioural Therapy (DBT)

DBT provides individual therapy skills training and the use of intersession time for application of new skills. A strong therapeutic alliance (TA) is the most powerful contingency in therapy. The pre-treatment stage focuses on commitment, orientation to therapy, and the therapeutic relationship. The next stage focuses on core behaviours of MN by confronting therapy-interfering behaviours and increasing the range of function through group skills training. The therapy stage a power struggle with the therapist is expected and success depends on the TA. The TA is a challenge for narcissistic behaviour and a container for functional behaviour. Behavioural chain analysis is used to increase insight. Skills training includes: mindfulness that enables the experience of true feelings, distress tolerance focused on radical acceptance, learning about emotional functioning and the regulation of feelings and actions, and interpersonal effectiveness in communication particularly taking into account other peoples feelings (Linehan et al. 1999).

Individual Psychotherapy

The goal of individual psychotherapy is to develop insight. Insight is essential for individuals with MN to recognize that they have a problem and to understand the unconscious sources of their emotional symptoms and maladaptive behavior. Constructive change can only occur when an individual brings into consciousness the unconscious determinants of painful affects and self-defeating behaviors. In MN the unconscious conflict is usually related to repressed feelings toward important objects associated with deep-seated rage and hatred. The clinical study of patients with MN usually reveals unconscious and conscious envy as a major affective expression of aggression. (Kernberg 2004)

Severe narcissistic personality disorders with overt borderline functioning have a generalized lack of impulse control, anxiety tolerance and subliminal channelling. In these patients the intensity of aggression rises to a maximum and suicidal behaviors come to the forefront in certain environmental situations. Successful management of these patients usually requires careful assessment and treatment of coexisting disorders (Marcinko & Vuksan-Cusa 2009), pharmacotherapy, individual and family therapy (Marcinko & Bilic 2010) and careful attention to countertransference issues (Marcinko et al. 2008).

The core of psychotherapeutic interventions in MN usually center around issues of rage, envy and hatred. Rage represents the basic affect of aggression as a drive and rage explains the origins of hatred and envy as well as angry and irritable moods. The object of hatred is usually experienced as an object that in some ways possesses the goodness and values that the malignant narcissist misses and desires for him or herself. Reaching this awareness is not possible when pure hatred is directed at an object perceived as a dangerous, sadistic enemy. The aim of hatred is to destroy the source of frustration perceived as sadistically attacking the self. Envy is a form of hatred of another object who is experienced as sadistically teasing or withholding something highly desirable. Malignant narcissists have had a parental figure who seemed to be a good enough parent but had an underlying indifference and narcissistically exploited the patient as a child. (Kernberg 2004)

Malignant narcissists must take full responsibility for their treatment and want treatment more than the therapist for therapy to be successful. Narcissistic behaviors should be approached with insight-informed psychotherapy and psychoanalysis which place greater emphasis on revelation and interpretation of the unconscious and thoughts and feelings that lead to unsettling feelings and self-defeating behaviors (Kernberg 2004).

Transference and Countertransference

In the treatment of patients whose transference is dominated by hatred, it is essential to establish a rigorous, flexible and firm frame for the therapeutic relationship. An effective therapeutic alliance is required to control life-threatening and treatment-threatening behaviors. The therapist must experience him or herself as safe in order to be able to analyse the deep regression in the transference. Psychotic transferences should be resolved first. Establishing a treatment contract for patients who are suicidal or who are engaged in dangerous behaviors or other types of destructiveness encourages the expression of hatred in the transference rather than into alternative channels of somatization and acting out. Any distortions of verbal communication and deception must be addressed as failing to do so encourages more paranoid tendencies. The patient is likely to experience strong tendencies of role reversal. This means that the patient unconsciously identifies in the transference with both the victim and the victimizer as well as projecting these representations onto the therapist. The patient is likely to alternate

between experiencing interactions as a victim and a victimizer and this paradigm will be repeated again and again. The therapist must attend to countertransference issues when faced with the cruelty and sadistic behavior of the patient. The therapist must be extremely alert to the core countertransference issues: painful experiences of being a victim and the temptation to act out strong aggressive countertransference reactions as the victimizer. The tendency to avoid analysis of the patient's identification with the aggressor and treating the patient as only a victim facilitates

the projection of the aggressor role outside the transference. This perpetuates an idealized transference dissociated from the basic dyad controlled by hatred and thus perpetuates the patient's psychopathology. That patient must be treated as a responsible adult (Kernberg 2004).

Couple Therapy

There are several common patterns in narcissistic couple relationships. The most common is *couples who blame* each other and show cohesiveness despite a chronic state of relationship stress and symptomatology. They usually have high levels of impulsivity and reactivity and tend to alienate their families and isolate themselves. The level of manipulation in these relationships is high and it is one of the major focuses of treatment.

Preoccupied couples are most often high achievers who are successful in their vocations and in social circles. External obligations are frequently used as an excuse for intimacy. The underlying dynamic in these couples is the inability to develop a nurturing and intimate relationship. A common manifestation in these couples is a high level of mutual reactivity. These individuals have a strong tendency to conceal inadequacies and project their unresolved emotions onto their partner. The conflicts are usually covert and difficult to recognize.

The goal of treatment in narcissist couples is to reduce reactivity and collusion defenses, to teach partners to avoid using humiliation, and to enhance empathy in order to allow growth and change (Sholevar & Schoweri 2003).

FAMILY THERAPY

In family therapy it is important to work on loving and valuing children for who they are, promoting autonomy and self-expression, family members developing a mutual sense of responsibility and the promotion of humanistic and spiritual values. The target of family therapy interventions should be the parental figures as the malignant narcissistic most likely chooses a partner who will fit with his or her narcissistic needs.

In families with one member suffering from malignant narcissism or with both partners having narcissistic personality it is possible that one of the children will develop borderline personality disorder. Their developmental history indicates a pervasive fear of abandonment, a fear of being alone, and feelings of emptiness and despair. It is likely that parental figures who are narcissistic are preoccupied with themselves. A pathological relationship before the age of 3 years leads to a poor sense of autonomy. Having had unstable and inconsistent parenting can mean having repeated trauma in childhood such that there is a deficient resolution of symbiosis, a failure of the separation-individuation process and an inability to form an autonomous ego (Marcinko & Bilic 2010).

The family life of people with borderline personality disorder is marked by impulsivity, violence, suicide attempts, substance abuse and conflictual relationships. The ultimate goal of family therapy is for family members to learn the value of negotiated agreements. It is hoped that family members will learn the disappointments are supposed to be solved through meaningful communication and the application of problem-solving methods. The disturbances in family relationships can be addressed by concentrating on the lack of problem-solving skills. The concept of differentiation is highly effective in correcting structural and boundary deficiencies in these families (Bowen 1978).

Introduction to Family Therapy

The main problem in recognizing the pathology of MN is that families and the majority of non-professionals and professionals do not recognize malignant narcissism. Pathological jealousy, aggression, hatred, sadism and paranoia should provoke the knowledgeable mental health professional to seek a family assessment. Usually there are serious problems with the children involving criminal activities, substance abuse, problems at school, poor achievement, suicidality, or borderline acting out that bring the family to therapy. Family assessment is very important in cases of depression, children's problems such as children who are allowed to be seen but not heard, suspected domestic violence, borderline personality disorder, partnership jealousy and where relatives and friends are aware there is something wrong in the family. The problem may be that the family has everything material but no happiness.

Assessment of Families at Risk of Producing Members with Personality Disorders

The authors have organized family assessment around covertly and overtly dysfunctional patterns in the following categories: 'families in nice wrappings', 'families with dangerous goods', and 'families in fragile packages'.

Families and societies have reciprocal influences on each other. Overtly and covertly dysfunctional families are at risk for producing individuals who suffer from

mental disorders, are destructive towards other individuals and families, are destructive towards society and the world, have serious flaws but come to power with the support of members of society who need a leader who expresses their repressed hatred and aggression. Societies on some level support authoritarian and narcissistic families out of a desire for obedient citizens and the need for competition, greed and success at any cost. Some societies and religions tend to promote authoritarianism. The family is the authoritarian state in miniature to which the child must adapt. The moral inhibition of a child's natural sexuality makes a child afraid, shy, fearful of authority and freedom, obedient, "good" and docile (Reich 1970). People raised in authoritarian families promote and advocate for leaders who ironically are destructive toward their society and at risk for being racists (Reich 1970). Societies and religions appear to emphasize family values. However, the values that sometimes dominate society and religious institutions are greed for power and wealth. These values undermine family function and promote dysfunctional families and corrupt societies. Functional societies promote the importance of education, health and social services for individuals and families. The consequences of promoting greed for power and wealth are reflected in how governments prioritize expenses for war and aggression and minimize the importance of education, health and social services for families.

I. Families in Nice Wrappings: Narcissistic Family Systems

Families in nice wrappings are narcissistic families. They are socially well-presented, respected and rarely come to the attention of social services. Parents are usually educated, successful and follow conventional religious and social values. Dysfunctional family patterns can be recognized only by a psychologically-minded relatives or friends. These families have both *covert* and *overt* dysfunctionality.

Covertly Dysfunctional Narcissistic Family Systems

Covertly dysfunctional narcissistic families show no obvious trauma, no mental disorders, substance use disorders or physical and sexual abuse. The children are well cared for. They are well fed, nicely dressed, birthdays are celebrated, the families enjoy holidays, and the children graduate from good schools. Children have good manners. They are respectful, pleasant and are social achievers. We will discuss two categories of *covertly* dysfunctional families using archetypes from Greek mythology: Hera's narcissistic family system and Demeter's narcissistic family system.

Hera's Covert Narcissistic Family System. The family system is narcissistic. Parents are absorbed in self-reflection and are unable to see, hear, or react to their children's needs. The parents are emotionally detached from their children, lack empathy and put themselves and their needs first. (Pressman & Pressman 1994) The mother resembles the Greek goddess Hera. She is completely dedicated to her husband and cannot tolerate anything that threatens her husband's social or professional status, ego or peace of mind. The social status of the family is the most important and children have to serve that purpose. Attachment is avoidant (Bowlby 1988) and the family system is disengaged (Minuchin 1974).

The children of Hera's Narcissistic Family become the reflection of their parent's emotional needs. They are like a shadow or an Echo from the Myth of Narcissus. They are unable to succeed in capturing their parent's attention or love. They loose the ability to form their own words and can only repeat the utterances of others. Echo is a symbol of a reactive personality with an impaired sense of self and lack of self-knowledge.

Children from these families have a vulnerable core, caustic anger and hatred masquerading as humor, low self-esteem, and problems with isolation and intimacy. They are successful in their careers and are usually workaholics who have no pleasure or satisfaction in their profession or private lives. Something is missing. They cannot understand their feelings or their problems in interpersonal relationships. These individuals spread their concealed unhappiness to society. As the Dalai Lama says, "Hatred and anger are considered to be the greatest evils because they are the greatest obstacles to developing compassion and altruism…" (Dalai Lama & Cutler 2001).

Demeter's Covert Narcissistic Family System. In Demeter's covert narcissistic family the mother is dominant, protective and controlling. The parents' relationship is vulnerable. Both partners are disappointed in each other. The mother expected her partner to be socially successful and the father expected his partner to be a devoted lover. The relationship only exists because of children and the social stigma of divorce. The parents did not gain the education or social status they desired. They love their children and help them in difficult times, but the children are mainly seen as a 'windows of opportunity' for the parents to attain their unfulfilled needs for social and financial success. The parents mostly neglect children's need for autonomy and self-expression.

The children of Demeter's narcissistic family feel obliged to fulfil their parents' dream. They become achievers but loose their authentic self and have ambivalent feelings towards authority. The children are used for parents' narcissistic needs. The parent's relationship is less important, the children's emotions are not neglected on a superficial level, but the children's need for autonomy is completely dismissed.

When these children reach adulthood, they may seek psychological help at the urging of their partners or children who recognize that 'something is wrong'. These people have strong family loyalties and it may take a long time for the individual or therapist to recognize the emotional trauma in the family of origin. Attachment is usually avoidant and family system has a tendency to be enmeshed.

These children usually have problems with identity, trust and interpersonal relationships. They are more interested in materialistic than spiritual values. Repressed anger is expressed through covert sadism, jealousy, competitiveness and success at any cost. The children are prone to be followers and not leaders but once they attain power, they are greedy, ruthless and insatiable.

Overtly Dysfunctional Narcissistic Family System

These families are socially privileged, well-off or of average income, but are perceived as organized and successful. Religious values are neglected. The father is dominant. The extended family, family friends and even public often witness the parents' ambition and cruelty, emotional, occasional physical and possibly sexual abuse. The basic needs of the children are looked after. The family spends a lot of time together. All the family dramas happen under the superficial smile and politeness of family members. The parents are highly controlling. Family values are organized around the parents' needs for social status and success at any expense.

The children of overtly dysfunctional narcissistic families are only 'narcissistic extensions of their parents'. The children's emotional needs are neglected. Parents spend time listening to children's' frustrations but impose their values and ways of solving problems on their children. If children are not performing according to the parents' needs for a socially successful family, children are ignored, treated with emotional cruelty, physical abuse and public humiliation. Children are forced or 'brain washed' to be successful in sports, politics and professional carriers. Their attachment is avoidant, or anxious ambivalent and the family system is disengaged or enmeshed.

These children are prone to anger, rivalry, competition and jealousy, as well as overt hostility, cynicism, interpersonal problems, alcohol and drug abuse, identity confusion, and narcissistic and sadistic personalities. They project and displace their aggression onto others, exhibit hidden or overt racism and persecution of others.

II. Families with Dangerous Goods

These families are authoritarian and their children may become malignant narcissists or show antisocial behaviors or personalities. These children may become serial killers or mass murders and even brutal, ruthless dictators.

Authoritarian Family

The majority of dysfunctional families are authoritarian. Family members rarely come to the attention of family therapists because most societies rely on this kind of family structure. Some cultures advocate for absolute obedience of children and females. Individuals from these families come to treatment through problems of their children, for couples' therapy because of dominating, controlling and sadistic partners, domestic violence and forensic problems. In these families the parents are always right and they are the masters of their children forever. Every act of cruelty for these parents in their words is an expression of love (Adorno & Frenkel-Brunswik 1950, Miller 1990).

The children of authoritarian families often have their individual will broken during the first two years of life when the children have no memory of what happened and will never be able to blame their parents. Later the children are prevented from expressing sadness, anger, or rage and are unable to react to hurt, humiliation or coercion. These children's feelings are repressed, dissociated and remain unsatisfied without hope for fulfillment. In these families the children are held responsible for the parents' anger. Any life affirming feelings from the children pose a treat to the autocratic adults. Severity and coldness are promoted as a good preparation for life (Miller 1990).

These children suffer from antisocial, paranoid and sadistic personality disorders, substance use disorders, suicide, crime and mental illness. These individuals contribute to establishing an authoritarian society that is characterized by destruction, racism, violence, cultural intolerance, and crime.

Families of Serial Killers and Mass Murderers. Some children from authoritarian dysfunctional families become murders. Their motivation for killing involves the desire to dominate and control other people. These people are only occasionally seen by mental health professionals or family therapists before they commit a crime. The father is usually physically abusive, absent or passive. The mother was a victim of abuse and emotionally abandons her children. She is occasionally dedicated to religion. The child that becomes a murderer has a desire for revenge and feels rejected and humiliated by the family. This child has a killing instinct towards the father and blames the mother for not providing love and nurturing. There is a prominent hatred towards the family (Douglas & Olshaker 1999).

III. Families in a Fragile Package

These families are both *covertly* and *overtly* dysfunctional. The family system is dysfunctional with disturbed roles, boundaries, communications, responsibilities and values. One or both of the parents have a history of trauma or family members who suffer from psychiatric problems or substance use disorders. Research has shown that children whose parents suffer mental illness have higher rates of emotional and behavioural problems (20-25% likely compared to 10-20% of general population). There is an increased incidence of abuse and neglect of children (Farrell et al. 1999, Jablensky 1999, Meadus 2000).

Covertly dysfunctional families rarely come to therapy voluntarily. Viewed superficially from the outside these families appear functional and caring but there is a tension in the parental relationship and the mother is overly reactive. The children's problems may

be recognized by teachers, pediatricians and school psychologists. These families have 'secrets and lies'. The secrets are about abuse, mental illness, suicide, losses, adoption and illegitimacy. The lies are related to relationship problems, extramarital affairs, sexual identity, social and financial problems. The main problem in the family is insecure attachment where care and giving interactions are characterized by conflict and ambivalence. Children's behavior activates the unresolved suffering of the parents due to previous trauma, illness or losses.

Covertly Dysfunctional Family Systems

Covertly Dysfunctional Families are of two types: A) Role reversed child- abdicating parents and B) Families with disorganized attachment (Erdman & Caffery 2003).

Role Reversed Child- Abdicating Parent. In these families the children's' role is to sooth and organize the distressed parents. The mirroring relationship is reversed. The children show an extreme sensitivity to the mother's mood and this results in compulsive caring by the children (Erdman & Caffery 2003). The parent's subsystem is conflictual. The father is disengaged or mother is a solo parent or has a mental or addictive disorder. The family system is enmeshed (Minuchin 1974).

These children as adults suffer Psychosomatic Disorders and Dependant traits. They are unable to fulfil their roles as parents or fulfil their potential in contributing to society (Erdman & Caffery 2003).

Families with Disorganized Attachment. This family system is associated with traumatic care giving. The parents are a source of threat and abuse. This sets up approach-avoidance oscillations. This pattern is seen in families where the parents suffer from affective disorders, borderline personality and alcoholism (Pressman & Pressman 1994). The parents have experienced trauma such as loss, separation, and abuse. The traumatized parents are unable to cope with their children's needs and distress. The children use extreme defenses to maintain some sort of internal coherence including splitting, dissociation, and an excessive need for control. Splitting is used because of a pervasive fear of abandonment (Holmes 2001)

These children develop borderline personality disorder and other mental disorders, including self-harming behaviours, suicide and substance use disorders. As adult they are dysfunctional in their interpersonal relationships, in meeting their expectations as self sufficient members of society and they may show criminal behavior.

Overtly Dysfunctional Families

These families have obvious problems that are recognized through the behaviour of family members. They are frequently seen by mental health professionals, social institutions, and the criminal justice system. Physical, sexual, and emotional abuse is prevalent. Family members suffer from substance use disorders, criminal behaviour and serious mental disorders. There are pervasive socio-economic and cultural problems.

These children develop mental disorders, personality disorders, substance use disorders, suicide and psychosis. The consequences for society include rebellious behaviour, violence, crime, and mental disorders.

DISCUSSION

There is a small body of historical and theoretical knowledge about MN but no objective data. An instrument or structured interview that identifies MN would be useful. The Diagnostic Interview Schedule for NPD (DIN) (Gunderson & Ronningham 2001) could be used in combination with schedules that identify antisocial, paranoid and sadistic features. This would require research validation.

The ability to describe and understand the development and treatment as well as the personal and family consequences of MN is within the grasp of psychiatry and needs continued attention and development. The social consequences of MN are profound. The role of society in enabling malignant narcissists as leaders needs to be understood and addressed. Psychiatry has an important contribution to make toward this endeavour but it clearly involves other disciplines in the social sciences including political science, history, sociology, psychology, anthropology, and economics.

Societies tend to admire special gifts, power, wealth and status but are not as concerned about individual human suffering or individual authenticity. Throughout history it is aggressive civilizations that survive for the longest periods of time (Campbell & Moyers 1991). Children who come from authoritarian families with a strong, powerful and sadistic parent are at an increased risk for developing Personality Disorders (Miller 1990). Social authorities are strong role models for parents. Power, control, and humiliation of dominants towards subordinates pervade many social relationships (Miller 1978). Modern society discourages the development of an anima in males, the empathetic part of the soul that relates to the psychological needs of others.

Of all the disciplines of medicine, psychiatry is the most connected to the social dynamics of society. It is worth considering whether this affiliation is part of why MN has been so poorly recognized and addressed.

Looking back to the information that comes to us from the study of fairy tales and elementary ideas we can see that the evil stepmother resembles not only family members with MN but also dictators, cult leaders and other social figures. In the elementary ideas expressed in these fairy tales we can see the father as a symbol or representative of society. The father is more concerned about himself than he is about his child. He doesn't love the evil stepmother but forms an alliance with her because he wants to be seen as powerful. He

doesn't interfere with the activities of the stepmother and he doesn't protect his own child. The step child in these fairy tales is someone who is different. She becomes the object of hatred and persecution because she does not belong to the evil stepmother. The step child is a symbol of people who are innocent, less powerful and different in families and society. The evil stepmother is not punished in theses fairy tales. She is not held responsible for her actions nor is she asked to redeem herself. In many ways the fairy tales parallel the current social approach to MN and the approach of modern psychiatry. The failure of psychiatry to undertake further study of MN after Kernberg introduced the topic in 1984 reflects the same dynamic. This dynamic suggests that society, including psychiatry, is not ready to accept or overcome the elemental ideas represented by the concept of MN. As Bettleheim suggested (Bettleheim 1981) we mix fantasy with reality throughout our lives and our vision of reality continues to be clouded by our emotional needs and our desire to hold onto to fantasies at the expense of listening to our rational thoughts.

Suggestions for psychoeducation to promote the evolution of social consciousness include education and social support. Education about MN needs to be provided for all professionals involved in the early care and education of children. Social pressure and reinforcement should be provided by the professional medical, judicial, correctional, therapeutic, educational and ecumenical community to adopt a position of zero tolerance to child abuse. Early intervention is essential for abused children. An accessible, well-established family support system in the community would be of tremendous benefit. Government support is essential for the development and utilization of therapeutic communities for personality and substance disorders. It is essential that child protective services, the judicial system and families understand that people with MN will not voluntarily cooperate with treatment and must be coerced. A transformation of the collective consciousness of society is required to move past the realm of enchantment with narcissistic values and passive resistance toward authenticity and responsibility, respect and compassion for children and integration of that which is projected onto others.

REFERENCES

1. *Adorno T & Frenkel-Brunswik E: The Authoritarian Personality. New York: Harper, 1950.*
2. *Akhtar S: Broken Structures; Severe Personality Disorders and Their Treatment. New York: Jason, 1992.*
3. *Akhtar S: The Damaged Core: Origins, Dynamics, Manifestations and Treatment. Northvale, NJ: Jason Aronson, 2009.*
4. *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, D.C.: American Psychiatric Press, Inc., 2000.*
5. *Bettleheim B: Why should a therapist know anything about fairy tales? Images, Myths and Fairy Tales; Timeless Therapeutic Tools. UCLA: UCLA Extension Lifespan Learning Institute Audio CD Series, 1981.*
6. *Bowen M: Family Therapy in Clinical Practice. New York: Jason Aronson, 1978.*
7. *Bowlby J: A Secure Base: Clinical Applications of Attachment Theory. London: Routledge, 1988.*
8. *Campbell J: Psyche and Symbol. Images, Myths and Fairy Tales; Timeless Therapeutic Tools. UCLA: UCLA Extension Lifespan Learning Institute Audio CD Series, 1981.*
9. *Campbell J & Moyers B: The Power of Myth (editor B.S. Flowers). New York: Anchor Books, 1991.*
10. *Clarkin JF, Yeomas FE & Kernberg OF: Psychotherapy for Borderline Personality. New York: John Wiley and Sons, 1999.*
11. *Cloninger, C.R., Przybeck, T.R., & Svrakic, DM: Emotional features of narcissistic personality disorder. Am J Psychiatry, 1985; 143:720-724.*
12. *Cloninger CR, Svrakic DM, & Przybeck TR: A psychobiological model of temperament and character. Arch Gen Psychiatry, 1993; 50: 975-990.*
13. *Dolan B & Coid J: Psychopathic and Antisocial personality disorder. London: Gaskell, 1993.*
14. *Douglas J & Olshaker M: The Anatomy of Motive. New York: A Lisa Drew Book/ Scribner, 1999.*
15. *Erdman P. & Caffery T: Attachment and Family Systems. New York and Hove: Brunner-Rouledge, 2003.*
16. *Farrell G A, Handley C, Hanke A, Hazelton M & Josephs A: The Tasmanian children's project report: The needs of children and adolescents with a parent/carrier with a mental illness: Tasmanian School of Nursing and the Department of Health and Human Services, 1999.*
17. *Fromm, E: The Heart of Man. New York: Harper and Row, 1964.*
18. *Gabbard GO & Twemlo SW: The role of the mother-son incest in the pathogenesis of narcissistic personality disorder. J Am Psychoanal Assoc, 1994; 42: 1083-1106.*
19. *Glad B. Why tyrants go too far: Malignant Narcissism and absolute power. Political Psychology, 2002; 23: 1-37.*
20. *Gunderson JG & Ronningham E: Differentiating narcissistic and antisocial personality disorders. J Personal Disord, 2001; 15: 103-109.*
21. *His Holiness the Dalai Lama & Cutler H: The Art of Happiness. Australia: Haghette, 1998.*
22. *Holmes J: The Search for the Secure Base. Hove, East Sussex: Bruner-Routledge, 2001.*
23. *Jablensky A, McGrath J, Herrman H, Castle D, Gureje O, Morgan V & Korten A: People living with psychotic illness: An Australian study 1997-98. An overview. Commonwealth of Australia, 1999.*
24. *Kauffman M: Paranoid disorders: The interpersonal perspective. Journal of Family Therapy, 1981; 3: 21- 30.*
25. *Kernberg OF: Borderline Conditions and Pathological Narcissism. New York: Jason Aronson, 1975.*
26. *Kernberg OF: Severe Personality Disorders. New Haven, CT: Yale University Press, 1984.*
27. *Kernberg OF: Aggression in Personality Disorders and Perversions. New Haven: Yale University Press, 1992.*
28. *Kernberg OF: Aggressivity, Narcissism, and Self-Destructiveness in the Psychotherapeutic Relationship. Yale University Press, 2004.*

29. Kohut H: The Analysis of the Self. New York: International Universities Press, 1971.
30. Kohut H: The Restoration of the Self. New York: International Universities Press, 1977.
31. Li Z: The Private Life of Chairman Mao: Memories of Mao's Personal Physician (HC Tai, Translation; AF Thurston, Ed.) New York: Random House, 1994.
32. Lifton RJ: Thought Reform and the Psychology of Totalism; A Study of "Brainwashing" in China. USA: Norton & Co., 1961.
33. Lifton RJ: Revolutionary Immortality: Mao Tse-tung and the Chinese Cultural Revolution. New York: Random House, 1968.
34. Linehan MM, Schmidt H, Dimeff LA, Craft JC, Kanter J & Comtois KA: Dialectical Behavior Therapy for Patients with Borderline Personality Disorder and Drug-Dependence. Am J Addict: The official Journal of the American Academy of Addiction Psychiatry, 1999; 8: 279–292.
35. Marcinko D, Skocic M, Saric M, Popovic-Knapic V, Tentor B, Rudan V: Countertransference in the therapy of suicidal patients-an important part of integrative treatment. Psychiatr Danub 2008: 20 (3): 402-405.
36. Marcinko D, Vuksan-Cusa B: Borderline personality disorder and bipolar disorder comorbidity in suicidal patients: diagnostic and therapeutic challenges. Psychiatr Danub 2009; 21:412-425.
37. Marcinko D, Bilic V: Family therapy as an addition to individual therapy and Psychopharmacotherapy in late adolescent female patients suffering from borderline personality disorder with comorbidity and positive suicidal history Psychiatr Danub 2010; 22: 211-214.
38. Meadus R J & Johnson B:The experience of being an adolescent child of a parent who has a mood disorder. Journal of Psychiatric & Mental Health Nursing 2000; 7:383-390.
39. Miller A: For Your Own Good: Hidden Cruelty in Child-rearing and the Roots of Violence. The Noonday Press: New York, 1990.
40. Miller JB: The effects of inequality on psychology. Psychiatric Opinion, 1978; 15: 29-32.
41. Minuchin S: Families and family therapy. Cambridge, MA: Harvard University Press, 1974.
42. Montefiore SS: Young Stalin. Weidenfeld, Nicolson: London, 2007.
43. Moore LJ & Goldner-Vukov M: Malignant Narcissism: From the Snow White Syndrome to modern neurobiology. 44 International Neuropsychiatric Pula Symposium, 84 Neurologia Croatica, 2004; 53: 84-89.
44. O'Leary KM & Cowdry RW: Neuropsychological testing results in borderline personality disorder. In Biological and Neurobehavioral Studies of Borderline Personality Disorder (editor K.R. Silk). Washington DC: American Psychiatric Press, 1994.
45. Paley A-M: Discussion of "Why do people stay in hateful relationships? The concept of malignant vindictiveness" by Nathan M. Horwitz. Am J Psychoanal 2001; 61: 161-164.
46. Paris J: Personality disorders in sociocultural perspective. J Personal Disord, 1998; 12: 289-302.
47. Perry JC & Bond M: Empirical studies of psychotherapy for personality disorders. Am J Psychiatry, 1999; 156: 1312-1321.
48. Pressman S & Pressman R: The Narcissistic Family. San Francisco: Jossey-Bass, 1994.
49. Pye L: Mao Tse-tung: The Man in the Leader. New York: Basic Books, 1976.
50. Reddy I: Parenting in personality and personality disorder and Parental Bonding and Antisocial personality disorder. American Psychiatric Association Annual Meeting, 2002.
51. Reich W: The Mass Psychology of Fascism. New York: Farrar, Straus & Giroux, 1970.
52. Ronningstam EF: Disorders of Narcissism: Diagnostic, Clinical and Empirical Implications. Washington DC: American Psychiatric Press, 1998.
53. Rosenfield H: A clinical approach to the psychoanalytic theory of the life and death instincts: An investigation into the aggressive aspects of narcissism. Int J Psychoanal, 1971; 64: 269-178.
54. Schore AN: The effects of early relational trauma on right brain development, affect regulation, and infant mental health. Infant Mental Health Journal, 2001; 22: 201-269.
55. Sholevar GP & Schoweri LD: Family Therapy with Personality Disorders. Textbook of Family and Couples Therapy pp. 715-723. Washington DC: American Psychiatric Association, 2003.
56. Sievers L: Discussant, Trauma and the brain. American Psychiatric Association Symposium APA Annual Meeting, 2002.
57. Solof P: Psychopharmacology of Borderline Personality Disorder, Psychiatric Clinics of North America. Philadelphia: WB Saunders, 2000.
58. Stone MH: Long term follow up of narcissistic/borderline patients. Psychiatr Clin North Am, 1989; 12: 621-641.
59. Storr A: Feet of Clay: A Study of Gurus. London: HarperCollins, 1996.
60. Terrill R: Mao: A Biography. New York: Harper and Row, 1980.
61. Winnicott DW: Ego Distortion in Terms of True and False Self. London: Hogarth Press and the Institute of Psychoanalysis, 1960.
62. Yang J & Halliday J: Mao: The Unknown Story. London: Vintage Books, 2007.
63. Yudofsky SC: Fatal Flaws; Navigating Destructive Relationship with People with Disorders of Personality and Character. American Psychiatric Association, Washington, DC: London, 2005.

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