PSYCHOANALYTIC PSYCHOLOGY, 1986, 3(4), 327-339

Shame and Gender Issues in Pathological Narcissism

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This article demonstrates the importance of a close monitoring of the emotion of shame in psychoanalysis. Shame is distinguished from guilt, and its special relationship to pathological narcissism is discussed. A typology of narcissistic pathology is also described, which is mediated by the extent to which grandiosity is consciously experienced by the patient. Specifically, where grandiosity is conscious and central, there is a distinct shame avoidance quality. Males tend to be overrepresented in this category. Where grandiosity is disavowed, although unconsciously present, there is a heightened sensitivity to shame. Women seem to cluster here. Case illustrations of each type are included, and theoretical approaches by Lewis, Kernberg, Kohut, and others are discussed.

Shame is an emotion that has been receiving greater attention from psychoanalytic writers in recent years (e.g., Lewis, 1971, 1980; Morrison, 1983; Würmser, 1981). Many theorists stress the importance of shame in understanding narcissistic pathology. Indeed, some authors (e.g., Broucek, 1982; Kinston, 1983; Morrison, 1983; Würmser, 1981) argue that shame is the principal affect in narcissistic disorders. Lewis (1980) even describes narcissistic behavior as a defense against shame and recommends that it be subsumed under shame rather than the reverse.

In addition, those who do not specifically mention shame in their descriptions of narcissism nonetheless employ the language of shame in their discussions. A. P. Morrison (1983), for example, has documented this quite convincingly in Kohut's work. He points out that Kohut uses phrases like

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"disturbed self-acceptance," "mortification at being exposed," and "guiltless despair" when describing narcissistic character pathology.

In this article, we first review aspects of the literature on shame that are relevant to psychoanalytic psychotherapy. We then show the important role that shame plays in the spectrum of narcissistic disorders and, more specifically, how it contributes to a typology of narcissism. Finally, we suggest that the way patients handle shame may be related to gender and that narcissistic pathology tends to manifest itself differently in men and women.

SHAME DISTINGUISHED FROM GUILT

Until recently, shame was neglected in the psychoanalytic literature, and guilt was by far the more popular topic. Why was this so? Lewis (1971) provides an answer by pointing out that the typical reaction to shame is to hide or to run away. Patients and analysts both try to avoid it. Guilt, on the other hand, is relieved through confession and expiation. The analyst, therefore, is more likely to hear about the patient's guilt than about his or her shame, and consequently, guilt is more often discussed in the literature.

The first systematic review of these two emotions appeared in 1953 when Piers and Singer published *Shame and Guilt*. Many of their descriptions derive from structural theory. According to Piers and Singer, shame occurs when there is a failure to live up to one's ego ideal. Because the ego ideal is related to the internalization of admired aspects of the parents, failure to measure up produces tension. In this definition, "exposure," commonly cited as an aspect of shame, is mainly a process wherein one's failure is observed from the point of view of the internalized parental imago. Piers and Singer distinguish these experiences from guilt, where the emphasis is on the internalized aspects of the parents as punitive and restrictive. Guilt is generated whenever a boundary or rule set by the superego is transgressed; shame occurs when a goal set by the ego ideal is not being reached.

Differences in proneness to experience shame and guilt seem to be related to distinct identification processes during early childhood. Specifically, two routes of identification have been noted: anaclitic and introjective. Anaclitic identification, considered to be mainly preoedipal because it takes place during the first few years of life, is based on a strong symbiotic tie with the omnipotent, need-satisfying mother. Introjective identification comes later and is thought to be more oedipal in nature. It is conceived to be a defensive process in which the already established anaclitic identification sets the stage for an internalization of the punitive and restrictive qualities of a threatening parent (Freud, 1923). Research by Blatt, D'Afflitti, and Quinlan (1976) suggests an association between dependency/anaclitic and shame experiences on the one hand and self-critical/introjective and guilt experiences on the other.

As Lewis (1971) writes: "Identification with the threatening parent stirs an 'internalized threat' which is experienced as guilt. Identification with the beloved or admired ego ideal stirs pride and triumphant feeling; failure to live up to this internalized admired imago stirs shame" (p. 23).

Several writers have emphasized the interpersonal dimensions of shame and guilt (Lewis, 1971, 1980; Lindsay-Hartz, 1984; Morrison, 1985). Lewis (1980) refers to them as "attachment emotions," which she believes aim at restoring affectional ties but in different ways. She states: "Shame literally alters the self, which is experienced as helpless; in guilt the self actively attempts to alter things in the world" (p. 73). In shame states, a person feels helplessly exposed and dependent, which leads to more conciliatory, self-deprecating kinds of behavior. Indeed, self-awareness seems to be split between the painful, diminished self and the perceived disapproval of the other. This concern about the opinion of the other in shame states diminishes the boundaries of the self (i.e., a part of the self's experience is attributed to the other; Morrison, 1985).

In states of guilt, on the other hand, the individual is busy obsessing and/or manipulating the world in order to determine levels of culpability or to stave off punishment for transgressions. Also, the focus is less on the self and more on one's value system, actions, failures to act, and events for which one bears responsibility. Because guilt tends to evoke concern about the moral goodness or badness of a voluntary action, the focus is on aspects of the self. With shame, there is a greater focus on how well the whole self has lived up to an internal ideal. In general, then, shame involves a more profound experience of the self.

Because the self is the focus of awareness in shame, issues around "identity" are more pronounced (see Erikson, 1963; Lewis, 1971; Lindsay-Hartz, 1984; Lynd, 1958; Morrison, 1985). In shame states, we see ourselves through the eyes of another. This is like looking at ourselves in a mirror and finding ourselves to be wanting. We realize we are not who we want to be, and there is no escaping that it is truly us. The words of one of the subjects in Lindsay-Hartz's (1984) study illustrates this. The interviewee was a 30-year-old woman who was reporting on her experience of being caught shoplifting. "It was not just that people thought of me as bad, but I was a thief and people knew it" (p. 696).

SHAME AND PRIDEFUL GRANDIOSITY

Because shame and identity issues are so closely linked, it has occurred to us that self-deception and shame might be similarly linked. Sullivan's (1956) discussion of pride offers important insights in this regard. He describes pride from a pathological point of view (i.e., as the presenting aspect in an

elaborate self-deception). For Sullivan, pride is a facade or strategy that a person employs to prop up areas of the self in which there is some real deficiency. This "false" pride is maintained by selective inattention, which involves ignoring or bypassing negative information about the self. The demise of pride, or the generation of humiliation, a variant of shame, comes about when the person cannot avoid looking at the true nature of his or her incompetence in the presence of another. This is often a sudden, intense experience of being both exposed and deficient in the eyes of the other.

With his emphasis on the illusory nature of the pride system, Sullivan (1956) sheds light on the notions of "narcissistic grandiosity" as well as "narcissistic injury." That is, when an individual's elaborately structured pride system is undone, shame (narcissistic injury) follows. Thus, prideful or narcissistic grandiosity and shame have an intimate and reciprocal relationship. The former sets the stage for the latter. It would seem that the tenacity of grandiose defenses protects people from the painful shame feelings that may follow their undoing.

Thus far, we have seen that shame refers to what is often a sudden, painful experience of being seen by present and/or internalized others as defective, debased, or weak in a manner that seems to capture a selectively unattended truth about oneself. There is the sense that one's private world has been punctured and that one stands helplessly and glaringly revealed. We have also noted a powerful impulse to hide or cover up shame. Most important, we have highlighted shame as involving the whole self and described some links between prideful grandiosity and experiences of shame. We therefore believe that shame is of particular importance in the so-called narcissistic disorders in which both self-disturbance and grandiosity play such an important role.

RELATIONSHIP OF SHAME TO NARCISSISTIC PATHOLOGY

As noted earlier, many writers believe that shame holds a central place in narcissistic pathology. Broucek (1982), for example, writes that "shame experiences disrupt the silent automatic functioning of the sense of self, and shame is therefore considered to be the basic form of unpleasure in disturbances of narcissism" (p. 376).

Broucek also cogently argues that Kohut and Kernberg do not recognize the importance of shame dynamics in their discussions of narcissistic disorders and that this contributes importantly to the discrepancies in their views of narcissistic personalities and to the diagnostic confusion around the concept of narcissism. According to Broucek, Kohut emphasizes the denial and disavowal by the narcissist of the grandiose self. These patients show a depreciated actual, or real, self that is characterized by feelings of shame. Kohut's

narcissist, therefore, has a consciously vulnerable quality. Kernberg, on the other hand, describes the narcissist as disavowing the actual self and unabashedly embracing the grandiose self. As a result, he or she is likely to present as shameless and invulnerable. Hence, the two writers are really talking about two sides of the same coin. Broucek (1982) writes that the "keystone affect" (p. 369) linking their analyses is shame, and neither Kernberg nor Kohut gives this feeling the central relevance it deserves.

The understanding of narcissistic pathology may be advanced and diagnostic confusion may be reduced if a variety of types of narcissistic disorders are recognized, all linked by the centrality of the affect of shame in the narcissist's conscious and/or unconscious experiences. Our review does indeed suggest that there are at least two subcategories that are being described under so-called narcissistic disorders. In one of the categories, shame is repressed or dissociated, and a shameless grandiosity seems to occupy the center stage of the individual's conscious experience; in the other category, issues of shame and defectiveness are at the center of conscious experience, and expansive, elitist, and arrogant attitudes are denied or dissociated.

This view is similar to Broucek's analysis of narcissistic phenomena. He distinguishes between a narcissist that he calls the "unconflicted 'egotistical' type" (p. 376), who is shamelessly grandiose and self-centered, and a second narcissist that he designates "the dissociative type" (p. 376), who dissociates grandiosity, projects it onto idealized others, and suffers significantly from low self-esteem. In contrast to Broucek, however, we believe that the unconflicted egotistical type is not unconflicted at all, but rather is defending against, or selectively inattending to, powerful shame experiences. Therefore, the two kinds of narcissism cannot be properly diagnosed and understood without simultaneously taking into account conscious as well as unconscious experience.

SHAME, NARCISSISM, AND GENDER

It is noteworthy that these types of narcissism resemble stereotypical characterizations of male and female qualities in Western culture. Men are expected to exude confidence, to be daring, and to display their power. Women are expected to be more emotionally vulnerable. Thus, the discussion and descriptions of narcissism and narcissistic character pathology may have been complicated by gender-related phenomena.

Lewis (1976, 1978) has extensively discussed the differences between men and women regarding their experience of self. More specifically, she describes differences in the way men and women experience shame. According to Lewis, women are more prone to shame reactions than are men. This is a point of view shared by Freud, who felt it originated in women's recognition

of their castrated state. He wrote, "Shame, which is considered to be a feminine characteristic *par excellence* . . . has as its purpose concealment of genital deficiency" (1933, p. 117). Lewis, in contradistinction, believes it comes about because women are more centered on and sensitive to others than are men. For this reason, others will be able to make women more ashamed than men because shame is an affect that is so "other-connected."

Lewis attributes women's greater proneness to care for others to socialization processes that teach women to cultivate their affectionate bonds to others and to condemn more fiercely expressions of assertion and aggression. She relies particularly on the research on field dependence that she did with Witkin et al. (1954), which shows that women as a group are more field-dependent perceivers than are men. Also important is the experimental study she conducted with Witkin and Weil (Witkin, Lewis, & Weil, 1968) as well as other empirical studies (e.g., Gottschalk & Gleser, 1969) that show women to be more prone to experiencing shame.

Recent feminist analyses (Chodorow, 1978; Dinnerstein, 1976; Gilligan, 1982; Miller, 1976) are in agreement with Lewis that relatedness is a more powerful given in the lives of women. Additional support comes from the extensive work of clinician Robert May (1980), who undertook a comprehensive comparison of the fantasy productions of men and women.

May identifies a "pride" dimension in his male subjects that resembles the clinical term grandiosity. This pride dimension is reflected in a "cluster of attitudes and wishes that includes an inflated view of oneself, a touchy vulnerability to feelings of inadequacy, a worship of will and willpower, and a restless urge to achieve something outstanding" (p. 61). May indicates that the female fantasy pattern is more complex and various than the male pattern; therefore, it is harder to find one word to express the core meaning of the female pattern. "Endurance" was one candidate, but May concludes that "caring" is the word that does the most justice to the web of relationships characteristic of the female pattern.

May's female subjects also showed a greater concern for body boundaries as well as inner body contents. They tended to oscillate between feeling empty and lifeless inside or full of dirty, ugly stuff that they feared people would find revolting and offensive. In addition, his female subjects expressed greater inhibition about their aggressive impulses and had different defenses than males for dealing with such impulses. The female defensive pattern was to transform and contain feelings inside oneself or to turn against the self. The defensive pattern most associated with males was projection or finding someone else to blame.

Recent research on men's and women's perceptions of their bodies further complements Lewis' and May's findings and conclusions. Fallon and Rozin (1985) found that men and women both tend to distort their perceptions of their bodies. They further report that women distort their body perceptions

negatively, whereas men distort their body perceptions in a positive, self-aggrandizing way.

A few early psychoanalytic writers who focused on narcissism also alluded to the gender differences we are describing. Wilhelm Reich (1933), for example, described a phallic narcissistic personality type that resembles the grandiose, shame-denying type discussed here. This person tends to be exhibitionistic, arrogant, self-centered, and has an exorbitant expectation of the approval and admiration of others. Yet, Reich points out that on a deeper level these patients suffer from profound self-doubt regarding their masculinity.

Annie Reich (1953) discussed female pathological narcissism in a fashion that seems similar to the dissociative type of narcissistic disorder we are describing in this article. She indicates that the defensive maneuver engaged in by this kind of narcissist is to idealize the other, not the self, and then to identify subserviently with this powerful other and thereby to obtain narcissistic gratification indirectly.

Thus, although we are not suggesting that one type of pathological narcissism is exclusive to either males or females, we have concluded that the egotistical type is more commonly found in men and the dissociative type is more common to women. This may be caused by different patterns of defense that lead females to be conscious of shame experiences more often, whereas males more frequently tend to bypass or flee shame experiences. The following two cases have been selected to demonstrate these points concretely.

CASE EXAMPLES

Helen is a 28-year-old female patient who shows many of the characteristics of a narcissistic disorder in which shame is consciously manifest. Although she is a graduate from an elite college, she works as a secretary. Because she is efficient, diplomatic, and deferential, she is highly prized by her boss and earns a very good salary. Helen has resisted promotions that have been offered because of her dread of the shame that would come from failure at these more executive-like positions. She enjoys being "the best" at what she does and is privately disdainful of the other secretaries at the firm. She limits herself to situations where being the best is guaranteed or, conversely, to situations where there is no risk of being less than the best.

Helen is addicted to romance novels and admires men, particularly artistically talented men, from afar. She is, however, extremely self-conscious, often blushing in their presence. Few of these men are aware of her interest. She will not risk letting her interests be known because of the intense shame she associates with potential rejection. In addition, her background as a German

Jew growing up among poorer European Jews has taught her to feel superior, yet she is ashamed of those very feelings.

Her manner in treatment is to be apologetic about what she brings in for discussion. This, again, suggests her shame about being in the world in an assertive, "grand" manner. She is reminiscent of one of those characters in Russian novels who, although of noble birth, has fallen on hard times. That is, she is overtly self-deprecating, but this is the figure in a ground that suggests that she comes from a truly superior position. She acts as if her concerns are not worthy of either her time or the therapist's time. Her effect on her male therapist is to make him feel alternately wise and helpless. Thus, one consequence of her style is to induce a sense of impotence, suggesting that her deferential style may be masking grandiose, even aggressive, wishes to dominate. To have such wishes revealed to her could generate guilt and shame.

In a recent session, she was recounting an episode from a family gathering. Her older brother was home on a rare and celebrated visit. According to the story, her brother recited a poem from memory that Helen had written as a young child. Helen was touched by his gesture but remembers blurting out, "Yes, you weren't the only one with talent." This remark, which captured her rage at being displaced, was horribly embarrassing for her to have made because she had learned not to reveal ambitious or exhibitionistic inclinations. At this point in the session, Helen reported that she had a dream she wanted to tell. Struck by the abruptness of the transition to the dream, the therapist inquired as to what she was experiencing and not talking about. She said that while she was recounting the story about her brother she realized how petty it was for her to get so upset over this minor incident. She felt that she must look ridiculous in the therapist's eyes. When asked why she couldn't report these "second thoughts" on her own, Helen said she had already wasted enough time and would feel foolish continuing to talk about it. The therapist then asked what her experience was now as they were talking about this. Again, Helen indicated her shame in not being a better patient for the therapist. The therapist at this point began to feel he was in a hall of mirrors (i.e., wherever he looked, he found shame).

The dream, as it turned out, paralleled the very process taking place in the therapy. In the dream, Helen is at her occasional boyfriend's apartment. She and a group of other people, who seem to be fans of his, are sleeping on the floor. She quickly realizes that she doesn't want to be seen by her boyfriend, especially among these people, and begins frantically trying to figure out how to get into the bathroom, get dressed, and leave the apartment, all in one fell swoop. The dream ends with her feeling quite anxious.

The dream indicated a quality that is very common to shame-prone people (i.e., the wish not to be seen). More specifically, there is the fear of being seen in a debased way, sleeping on the floor. In the session, the very introduction of this dream was a way to escape from being seen by the therapist. Further,

the dream content not only paralleled the therapy session, but it also paralleled her childhood pattern of running from attention. This characteristic played into her parents' tendency to ignore her in favor of her less shy, more exhibitionistic brother.

A second patient illustrates a narcissistic disorder in which experiences of weakness or vulnerability are vigorously defended against, and achievement is compulsively pursued.

Jack, a man in his late 50s, is nearly always expansive and jaunty in therapy sessions, but he is also very controlling. For example, he talks in an almost pressured fashion, often making it difficult for the therapist to get a word in edgewise.

Jack's work requires a good deal of travel. Inquiries about the necessity for all his trips prove difficult because he has a strong need to be on the scene of every business activity, feeling that if he's not there and in control something will go wrong or that his business partners will do something that will tarnish his image as a crackerjack manager. He once abruptly left a company because the owners, in the process of rearranging the office, moved his desk and he, apparently inadvertently, wound up sitting in a new area that he felt was definitely of lower status.

Jack was raised in a manufacturing town in the eastern United States. When he finished his college education, he left this town and has never returned. He has been away for several years and never plans to return due to psychological injuries he feels he received there. These injuries were related to the fact that his family was not part of the high status manufacturing and professional elite that dominated the city's cultural and social life. In addition, he felt he was frequently excluded by his peers from the right "in" parties, particularly during his high school years. These events made him angry, but also made him feel defective and ashamed, and it was right out in the open for all to see.

Jack also had a long-term relationship with a woman, apparently the daughter of a European nobleman, who was highly contemptuous of American culture. Jack agreed with her about America and frequently condemned the country as primitive during the time he was in the relationship with her. Furthermore, he longed intensely to move to Europe, which he believed to be superior culturally.

Recent interactions in therapy have focused on his attitudes and feelings about his growing wealth. He has a sense that he is being flashy with this wealth, but he also says that if he has the second best of anything he feels bad. The manifestations of this wealth (e.g., riding in his big, powerful, expensive car) appear to comfort and soothe him. But in spite of his wealth, he has intense anxiety attacks over money. For instance, he will abruptly awaken in the middle of the night, panicked that he might not have enough money to pay his bills. This is a highly unrealistic fear given his income and expenses,

but it testifies to how deeply concerned he is about being found in a weak or defective situation. On other occasions, however, he will grandly refer to money as "filthy lucre."

He once dreamt that he was a tattered, physically exhausted bum in Rome, shuffling weakly from one friend's apartment to another's, hoping that one of them would take him in and care for him. The most painful part of this dream was the experience of people turning him away when he showed up at their place. He was afraid they wouldn't want a bum like him.

His exaggerated need for appearing in control and totally self-sufficient is revealed in a recent interaction at the office door at the conclusion of a therapy session. As he was walking out, he discovered that his wallet was missing. When asked if he had any cash to get around, he quickly responded, "No, no. It's only the credit cards that are missing. I have cash. I'll sort it out." This was followed by a wink and a smile. He then left. The message seemed to be, "Don't worry. Don't try to help me. I'm in charge, and I have no problem." There was no expression of dismay or upset. He remained quite cheerful about the whole matter.

DISCUSSION

The case material illustrates many of the difficulties encountered with shame in treatment. Because the nature of shame is such that people want to hide from it, patients do not readily introduce it. This tendency is evident even with a patient like Helen where shame is so consciously accessible. By remaining alert to the patient's potential to bypass shame experiences, her analyst helped her reveal deeper levels of transferentially induced shame feelings that could have gone unnoticed. For example, when Helen introduced the dream, the analyst experienced a powerful pull from her to focus immediately on it. Had he done that, he would not have attended to her shame at looking ridiculous in his eyes and failing to be a good patient. If that had happened, the dream content would have led into interpretations outside the room (e.g., her relationship to her boyfriend). Even more serious, in bypassing the shame experience, the analyst would have replicated for Helen her relationship with her parents where her most important inner experiences went unnoticed. In short, one consequence of being on the lookout for shame is that it helps to focus attention on transference–countertransference issues.

As noted earlier, not only are patients prone to circumvent shame, but analysts are too. An analyst may avoid exploration of the patient's shame because, through the normal processes of empathy and vicarious identification, the analyst is likely to experience these painful feelings as well.

Shame experiences and efforts to avoid them may be especially valuable for informing analysts about possible collusions with their patients. As

Levenson (1972) and Sandler (1976) have indicated, patients will often impose powerful role expectations on analysts that the analyst will consciously play out. These authors point out that the analyst's job is to unravel these collusions by a close monitoring of the analytic experience of both self and the patient. With Helen, for example, the analyst felt unusually self-conscious about the phrasing of his remarks to her. He often felt like a "bull in the china shop," with a corresponding tendency to restrain himself, make her comfortable (and himself), and avoid opening up potentially distressing matters such as her thoughts about how he was perceiving her.

There may also be advantages to using the language of shame. Nancy Morrison (1985), for example, points out that, because shame is a universal experience, it helps to minimize the use of technical language in relating to patients. Indeed, reliance on technical terms may have the effect of preventing the analyst from even noticing these affects in the patient. Furthermore, the language of shame, because it refers to commonplace human experience, has the added benefit of casting the situation in the language of normality rather than in the language of psychopathology. For instance, when working with Jack, who frequently uses projection as a defense (e.g., "America is bad"), it has proven to be more helpful to focus on his intense discomfort about potential exposure than on his reliance on projection. An emphasis on these mechanisms more than likely will mobilize him to become even more defensive.

Projection, or turning against the other, is one of the major defenses of the egotistical type, and there are cautions associated with the process of analyzing people who have such defenses. For instance, they are apt to misperceive the analyst's efforts at maintaining truthful engagement. Forthrightness will often be experienced as an attempt to humiliate. Therefore, it is particularly important to communicate acceptance. A strong climate of acceptance will help these patients work through their concerns and defensiveness about shame when the analyst, in the interest of candor, addresses important issues.

Working with egotistical types has other dangers. Their grandiose facade suggests that they can handle anything and that they are invulnerable. Analysts have to be careful not to let this facade beguile them into thinking that these patients have no difficulty with shame. The opposite more often proves to be true. For example, Jack's dreams and fearful night awakenings suggest that he feels terribly vulnerable. His defensive style, when awake, indicates that he is very much on guard against appearing weak or defective.

The experience of our cases (Helen and Jack) leads us to restate one of our central theses. In women, developmental and socalization processes tend to reinforce and heighten conscious shame. In men, these same processes reinforce hidden or unconscious shame. In part, this is an amplification of the view of Lewis (1976), who indicates that women are more shame-prone than

men. Most critically, these gender differences are exaggerated when pathological narcissism is present in the person's character. Pathologically narcissistic men, for instance, will be particularly prone to defend or hide their shame experiences. They are more ashamed of their capacity to be ashamed than most other people. Indeed, as Meissner (1984) remarks, there may be a countershame quality with certain patients that resembles the counterphobic behavior clinicians are familiar with.

We would particularly emphasize the importance of both developmental and socialization processes in producing these gender differences. They are not mutually exclusive in their effects on personality. Indeed, both combine to produce experience and behavior. For example, the countershame quality we noted in narcissistic males has its origins in the boy's intense identification with the more threatening and restrictive parent (i.e., introjective identification). This process is complemented by socialization processes that reinforce preoccupations with bigness, power, and invulnerability.

In conclusion, we find shame to be a powerful conduit to complex treatment phenomena. It can alert the analyst to important transference–countertransference issues. Also, the use of shame language in treatment has definite advantages over more pathologically based languages. Finally, an understanding of the centrality of shame in narcissistic pathology, as well as attention to subtle gender differences in experiencing shame, can improve the quality of our clinical interventions.

ACKNOWLEDGMENT

Previous versions of this article were presented at the Clinical Conference at the William Alanson White Institute, April 16, 1985; to Division 39 at the American Psychological Association convention in Los Angeles, August 25, 1985; and at the New York University Postdoctoral Program in Psychoanalysis & Psychotherapy, December 13, 1985.

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