Narcissism is a confusing psychiatric term. Originally it was used by Freud in a manner consonant with the ancient Greek myth of Narcissus. This was no accident, because the myth is profoundly insightful concerning the pathology of narcissism.

Narcissus was a beautiful youth, the product of the rape of the nymph Leiriope by the river god Cephisus. Leiriope was informed by a prophet that her son would live a long life provided he never knew himself. By the time he was 16 years old, as Robert Graves recounts, "his path was strewn with heartlessly rejected lovers of both sexes; for he had a stubborn pride in his own beauty." One of these repudiated lovers was the nymph Echo, who could no longer use her voice except to repeat the last sounds she heard. This was a punishment inflicted on her by Juno, whom she had deceived and distracted with beguiling stories while Juno's husband, Zeus, was unfaithful with the nymphs. Echo, who was lovelorn, approached Narcissus in the woods but could only repeat his words. "I will die before you ever lie with me," Narcissus cried. "Lie with me," she pleaded, repeating his words, but he abandoned her. Echo was heartbroken and pined away until only her voice remained. Later, a male suitor of Narcissus was spurned by him, and before killing himself he prayed to the gods, "Oh, may he love himself alone and yet fail in that great love." The goddess Artemis heard the plea and caused Narcissus to fall in love with his own image, which he saw in a reflecting pool and shattered every time he tried to embrace it. As Graves relates, "At first he tried to embrace and kiss the beautiful boy who confronted him, but presently recognized himself, and lay gazing enraptured into the pool, hour after hour. How could he endure both to possess and yet not to possess? Grief was destroying him, yet he rejoiced in his torments; knowing at least that his other self would re-
main true to him, whatever happened." Echo shared his grief and mourned as Narcissus plunged a dagger into his breast and died. From his blood sprang the flower that bears his name.

Many of the elements of pathological narcissism are cleverly incorporated into the myth: early psychological trauma and the consequent development of a sense of entitlement (Narcissus is the product of a rape); the absence of self-knowledge (most narcissists are oblivious to their pervasive and disabling disorder); egocentricity, arrogance, and insensitivity to the feelings of others (his treatment of Echo and the spurned youth); the desire and need of narcissists to have other people "echo" their thoughts and ideas; the absence of empathy for anyone but the self; disturbed object constancy (the fragmenting image in the reflecting pool); a mirroring transference (again the reflecting pool and the total love of only the self); and, finally, frustration and rage at the unattainable, leading to his suicide.

Freud initially viewed narcissism as a sexual perversion wherein the person's own body, as in the tale of Narcissus, was the object of desire. He subsequently used the term to delineate a normal developmental stage characteristic of infants and small children whose mental life is fundamentally egocentric. Gradually the concept evolved further to include a type of adult psychopathology characterized by grandiose self-importance, a failure to be concerned with the feelings of others, an inability to love someone else, and the exploitation of other people without any accompanying feelings of guilt.

Narcissism can be thought of as a universal dynamic theme of human psychology that is an essential and pervasive part of psychic structure. The concept possesses a spectrum of meanings. Narcissism organizes personality structure from the healthy to the pathological. Healthy narcissism is critical in maintaining basic self-esteem—the conviction that one is worthwhile—and the capacity to take pleasure in achievement, feel joy in being appreciated by others, and accept praise or rewards for one's accomplishments while sharing and acknowledging the role of others who were part of this success.

Narcissistic personality disorder is a relatively recent diagnostic category. Unlike most other personality disorders, it is not based on an extrapolation from the hypothetical psychodynamics of a symptomatic neurosis, on a description of nonpsychotic features of a psychotic disorder, or even on a cluster of maladaptive behavior traits. It began with psychoanalysts and psychoanalytic psychotherapists struggling to understand a group of particularly difficult patients who were not psychotic, not classically neurotic, and in general not responsive to traditional psychotherapeutic interventions and characterized not so much
by observable psychopathological phenomenology as by inferred psychodynamic patterns. The other personality disorder with a similar history is borderline personality disorder, but whereas borderline patients were soon recognized to exhibit a characteristic cluster of affective instability, chaotic relationships, life course, and at times deficits in autonomous ego functions, narcissistic patients were often viewed by the world as high functioning and without obvious psychopathology. Their problems were internal and related to the way in which they experienced themselves and others. They suffered, although they often denied it, the rest of the world often failed to recognize it, and only their therapists realized its depth. It seemed from the beginning that narcissism was more of a theme in mental life than a distinct nosological category. It was essentially universal, although more prominent in some than in others, and it could be associated with a wide range of pathology, from relatively healthy to seriously disturbed.

Narcissistic pathology is thus on a continuum from a mild form to more serious forms. In more serious cases, grandiosity and self-centeredness preclude sensitivity to the feelings of others, who exist in the patient’s mind only as a source of gratification and constant admiration. Such exploitation of others prevents any deep, caring relationship and reflects a vain and selfish individual who must constantly be the center of attention. When someone else is the celebrated person, the narcissist suffers inwardly, regardless of how unrealistic the competitive situation may actually be. For example, the severe narcissist may experience envy at the attention shown to a new baby, to a bride at her wedding, or to the eulogies given the deceased at a funeral. Pathological narcissism exhibits an oscillation between two feeling states: grandiosity and its opposite, a sense of nothingness.

The healthier, better-adapted, yet pathological narcissist is able to conform to social expectations. He seems comfortable with his accomplishments and has developed an outward appearance of modesty. Upon closer study, however, it is seen that he overestimates his importance and demands special treatment. These stronger wishes persist even though the person is considered to be successful. Secretly, he never feels satisfied with his achievements, and he experiences painful envy of the success of others.

The more subtle narcissist is a manipulator and can cause the other person to feel guilty for not offering whatever it was that he had wanted. The narcissist is easily hurt and responds with spiteful vindictiveness, which is often expressed with deliberate meanness. An example would be the mother who feels humiliated by some mild misbehavior by her child in front of others. She may smile and appear to offer gentle control
of the situation while covertly pinching the child in a fashion not visible to others.

Superego pathology is characteristic of the narcissist. The person with a milder form of this disorder possesses a superego that enables him to do "the right thing," but he does not feel particularly good about it. In essence, this aspect of psychic structure—an amalgam of parental values, moral and ethical precepts, decency, kindness, and so on—is not idealized in the way it is by other people. Doing the right thing does not enhance the narcissistic person's sense of self-worth. He does not feel proud of himself, because he is far more preoccupied with power and acclaim. He has idealized the grandiose ego ideal, not the superego.

It is the narcissistic deep-seated, inner greediness that has been the downfall of many highly successful and powerful people who never feel that they have "enough" despite enormous wealth and power. Success seems to intensify feelings of entitlement rather than to allow a feeling of peace and fulfillment with accomplishments. The narcissistic person will lie or cheat effortlessly in order to escape exposure and humiliation.

The DSM-IV-TR criteria for narcissistic personality disorder (Table 5-1) aptly capture the elements of the disorder in its more florid form. Milder variations, however, are common in clinical practice and can coexist with many other psychiatric disorders. A narcissistic individual can be quite charming, charismatic, self-confident, and superficially warm and entertaining. He has the ability to make another person, including the clinical interviewer, feel that he is also special. This reflects the narcissistic person's ability to psychologically incorporate another into his mental orbit of superiority and specialness as long as that person does not frustrate or contradict him. Over the course of time, this charming person reveals his lack of interest in the lives of others while expecting them to be interested in everything about him.

Although not included in the DSM-IV nomenclature, a common subtype of narcissistic personality disorder, the shy or covert inner narcissist, has been identified (Table 5-2). The shy narcissist is highly sensitive to slights or criticism. Where the criticisms are perceived as accurate, he responds with intense feelings of shame and humiliation. These same feelings of humiliation can be experienced when someone whom he views as a narcissistic extension—most likely a spouse, a child, or even a parent—performs poorly or embarrasses him. When the criticism or slight seems unjustified, he reacts inwardly with indignant rage and fantasies of exaggerated retaliation (e.g., .50-caliber machine guns mounted in the front fenders of his car to blast an aggressive driver who cut him off on the highway). The shy narcissist's arrogant counterpart
The Narcissistic Patient

TABLE 5-1. DSM-IV-TR diagnostic criteria for narcissistic personality disorder

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. requires excessive admiration
5. has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
6. is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
7. lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
8. is often envious of others or believes that others are envious of him or her
9. shows arrogant, haughty behaviors or attitudes


is more apt to drive a couple of feet behind the other driver and make hand gestures or to swerve around him or even try to run him off the road. The shy narcissist tends toward periodic feelings of depression. He often feels best when doing things by himself. In this way, he avoids competitive feelings of inferiority, envy, or shame in the presence of others.

The shy narcissist may have many acquaintances and a capacity to appear friendly but rarely warm. He has very few, if any, friends (particularly men) from various periods of his life. This is due to his caring more about what others think of him than caring about them. He is unlikely to know the names of his children’s friends or to have an interest in his “friends”’ children. It is this incapacity to sustain long-term relations that contributes to his feelings of isolation and being disconnected from people. His incapacity for genuine empathy is masked by his awareness of social expectations and a set of learned appropriate
### TABLE 5-2. Criteria for the shy or covert subtype of narcissistic personality disorder

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Description</th>
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<tbody>
<tr>
<td>(1) is inhibited, shy, or even self-effacing</td>
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<td>(2) directs attention more toward others than toward self and is uncomfortable when he becomes the center of attention</td>
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<tr>
<td>(3) is highly sensitive and listens to others carefully for evidence of slights or criticism or for praise and flattery</td>
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<tr>
<td>(4) responds to slights or criticism with inner anger and/or intense shame, humiliation, and self-criticism; responds to flattery with an exaggerated feeling of pleasure mixed with a sense of superiority and a feeling of having fooled people, mistrusting their motives</td>
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<tr>
<td>(5) is highly envious of the success and recognition achieved by others</td>
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<tr>
<td>(6) is unable to commit to others with unconditional love; lacks appropriate responsiveness to others; may not return letters or telephone calls because of a desire to be pursued; needs a constant source of gratification, as in the old song, “When I’m not near the girl I love, I love the girl I’m near.”</td>
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<tr>
<td>(7) lacks the capacity for empathy with others, or at best offers a calculated intellectualized empathy derived from figuring out the appropriate outward response; however, this response does not allow him to feel connected to the other person</td>
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<tr>
<td>(8) has compensatory grandiose fantasies that substitute for real accomplishments</td>
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<tr>
<td>(9) has a tendency toward hypochondria based on a response to feeling defective and inadequate; self-preoccupation easily focuses on health</td>
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**Source:** Modified from Gabbard 1989.
ogy from someone who has hurt him. He collects these hurts on a score card and inwardly feels, "Now you owe me." Like his first cousin, the masochist, he revels in the role of the injured party and strategically utilizes this position to extract favors from people or to otherwise manipulate them. Akhtar noted that in contrast to the arrogant narcissist, the shy narcissist has a stricter conscience and higher moral standards, with less inclination toward inconsistency regarding rules or ethical and moral values.

PSYCHOPATHOLOGY AND PSYCHODYNAMICS

Narcissistic Characteristics

Grandiosity

An exaggerated sense of oneself as uniquely special, unusually talented, and superior to others is a regular characteristic of the narcissistic patient. This inflated view of one's importance, even genius, is usually at odds with reality. Sometimes, however, especially in the artistic, political, scientific, or business world, the narcissist may be quite professionally talented and will receive reinforcement for his grandiosity by the critical acclaim of others. However, the narcissist's sense of superiority functions as a fragile defense against inner feelings of weakness, and it commonly has little objective correlation. "I am more important than Virginia Woolf was to English literature," declared a 30-year-old writer in a first interview. It quickly emerged not only that she had never been published but also that her literary output was limited and fragmentary and had never been shown to fellow writers, editors, or critics, because "they would not understand or comprehend its brilliance. Worse, if they did get it, they would be incredibly envious."

The extreme case of the arrogant or flamboyant narcissist is easily recognized. Shy narcissists do not display themselves in an obvious fashion, but they are secretly ready to feel slighted if they do not obtain the recognition that they feel is their due. In essence, they believe that their special presence and aura should be automatically perceived and responded to by those around them. If treated like everyone else, they will inwardly seethe. The shy narcissist has the same desire as the flamboyant narcissist to be applauded for special virtues but has a deeper fear of potential humiliation and shame if his grandiose fantasies are exposed.

Unlike the arrogant narcissist, who may be highly successful in a way that reinforces his grandiosity, the grandiosity of the shy narcissist
usually exists largely in fantasy. His deepest ambition is to be the very best, but inhibitions based on a fear of failing protect him from intense feelings of shame and humiliation. Hence he does not really exert himself to achieve because to do so would carry the risk of failure or non-recognition. The grandiosity implicitly exists underneath his dissatisfaction with his every achievement. He can briefly feel happy or even elated over a small recognition, but it is never enough. He soon compares himself with someone who has done more. He both over- and undervalues the importance of his accomplishments. This leads to a spotty work record because he becomes less confident in himself as he rises in an organization. More success is experienced as a bigger opportunity to fail and to face a more public humiliation. The more arrogant narcissist experiences success as his entitlement and tacit permission to play fast and loose with ethics and rules.

Although the narcissist can sometimes be witty at other people’s expense, the absence of a true sense of humor and an inability to laugh at oneself is characteristic of this disorder. The presence of fantasies of possessing transcendent charm, beauty, and intelligence are common. “My extraordinary radiance illuminates any room that I am in,” one narcissistic patient smugly described it. A graduate student in molecular biology who had an erratic career and was on the brink of being dropped from his program confidently exclaimed, “It’s inevitable that I will win the Nobel Prize. The fact that I have had problems with my advisors means nothing. Look at Einstein. He never got along with his professors.” This example speaks to the organizing aspects of narcissism. All aspiring or accomplished scientists may desire to win the Nobel Prize. It may be considered a universal fantasy for scientists. The scientist with healthy narcissism may possess this desire but will realize that award of the prize is based on how others estimate the value of his works and will have an understanding of the complexity of the politics involved in giving awards. The pathological narcissist, in contrast, has the conviction that he deserves the prize and has a desperate need for this accolade to support his grandiosity, unrealistic as the possibility may be in reality.

Grandiosity and its opposite—a deep sense of inadequacy—coexist in the narcissistic person. The clinical presentation will begin with one or the other. The patient may present complaining of professional failure or ineptitude in love experiences, but shortly thereafter his grandiose, overbearing, and imperious side will emerge. Alternatively, the grandiose and inflated side may present initially, but later in treatment profound feelings of inadequacy and inner emptiness will come to the forefront.
Lack of Empathy

An inability to be empathic with others is characteristic of the narcissistic individual. Empathy is a complex psychological phenomenon that includes the capacity to identify with another person and to transiently experience the other's emotional state. Empathy should be distinguished from sympathy, which is the genuine feeling of compassion for another person's pain or suffering, for example, the loss of a loved one. Empathy enables the listener to experience being in the other person's shoes while at the same time maintaining separateness. This capacity requires one to focus attention away from oneself, and it is absent in most narcissistic persons.

A narcissistic patient who was in the midst of a divorce, precipitated by his disclosure of an affair, bitterly complained, "I don't understand why my wife does not feel sorry for me. My life has been turned upside down, my kids are angry at me, my life is a mess. She just seems to want to persecute me, and that killer lawyer she is using is too much! How can she not care about how much pain I am in? I am suffering so much." He was incapable of feeling empathy for his wife's sense of loss, betrayal, and anger. He was the one for whom she should feel sorry, because he was suffering so much from the consequences of his actions.

More subtle failures of empathy are common. The narcissist is annoyed when his enjoyment of an evening is interfered with by some painful event in his partner's day. He may explode in a furious outburst if his partner, distracted by a family crisis, fails to praise his success. The accusation that the partner is "uncaring" will feel justified to the patient, who believes that he is the victim.

The ability to recognize what someone else is feeling does not, in itself, rule out the diagnosis of narcissism. The less extreme narcissistic person can identify another person's emotional state on some occasions. However, this is often based on inferences from external cues and not on inner feeling. On other occasions he has little or no emotional concern for the pain, distress, or feelings of the other person. While seeming to listen empathically, the narcissistic person is unconsciously storing information regarding the other person's vulnerable points to be used against that person on some future occasion when feeling criticized. These counterattacks are deliberate and show conscious meanness. Although the obsessive person may also engage in counterattacks when criticized, he does this from unconscious anger and a lack of tact, not the conscious sadism that is typical of the narcissist.
Entitlement

A profound sense of personal entitlement usually accompanies the narcissistic patient. “Of course I should not have to wait my turn,” exclaimed a narcissistic patient. Trying to set up a mutually convenient time for the initial clinical interview may reveal the diagnosis in advance of the first meeting. “That time isn’t good for me because of my workout schedule,” stated a narcissistic patient. “I can only come before lunch. Can’t you see me at 11:00?” The sense of entitlement is reflected in the conviction that the world should accommodate to him. Later in the interview the patient revealed, “My parents were cold and unfeeling. They gave me nothing emotionally. Of course I have to look out for number one; no one else will.” The emotional deprivation that the narcissist believes he has experienced leads directly to a type of aloofness and contemptuous arrogance in dealing with people who are regarded as having no significance, thus reversing the narcissist’s own experience of unimportance as a child.

A highly intelligent graduate student was confronted with compelling evidence of his having plagiarized published material and came for psychiatric consultation. He did not arrive in the clinician’s office of his own volition, but candidly admitted that seeing a mental health professional would bolster his defense against these charges and mitigate the consequences. Gradually, during the course of the interview, he conceded that “perhaps the files in my computer became confused so that I thought someone else’s writing was really mine.” He felt that the charges against him should be dismissed because it was simply an error of electronic transposition that whole pieces of a textbook had appeared in his papers as though they were his. “In any case, I’m the most brilliant student in the class. The authorities should make allowances for that fact.” When asked by the interviewer what he thought the difference was between lying and a mistake, he became confused. It took some time for him to concede that it was a matter of intentionality.

This example speaks to the automatic sense of entitlement that the narcissistic patient possesses. “What belongs to someone else can be mine if I wish. Honesty is no virtue since it may prevent me from getting what I want.”

Shame

Shame, as differentiated from guilt, is a common and painful affect for the narcissist. Morrison suggested that shame is an affect of equal importance to guilt in psychic life. Shame revolves around the experience of exposure of some failure or inadequacy and the consequent feeling
of mortification. Morrison included within the designation of shame feelings of humiliation, embarrassment, and lowered self-esteem. The narcissist responds to criticism or failure in some attempted achievement with a feeling that the self is inadequate and defective. An intellectually accomplished narcissistic patient who had a number of important publications to her credit became mortified and depressed upon receiving a rejection of her latest paper from a prominent journal. “I am nothing. My work is trivial and worthless. There is no point to my life. I just want to hide from everyone,” she exclaimed with bitterness and despair. The desire to hide is a classic response to the experience of shame. In some cultures in which shame is an excruciating and overwhelming affect, shamed and exposed individuals may feel that they have no recourse but to kill themselves, the ultimate form of “hiding.”

**Envy**

Envy plagues the narcissist who constantly compares himself with others in the hope of reinforcing his sense of superiority. Frequent feelings of inferiority stimulate a desire to devalue the other. “I’m so angry that she got the promotion and I didn’t,” complained a junior book editor. “I’m prettier, sexier, and far more charming than she is. Just because she’s smart and the writers she works with like her, she’s so empty. Doesn’t my company realize that image is everything? Looking good is what counts, not being likeable. I think I’m going to quit over this insult.” A mental health professional revealed his envy of the interviewer by commenting in the first interview, “Well, I know you are prominent and admired. I can tell from talking with you that your success is a consequence of the fact that you are just more effective than I am at controlling and manipulating the psychiatric world.”

**Narcissistic Devaluation**

Devaluation dominates the object relationships of the narcissistic patient. The distinctions are discussed in Chapter 10, “The Borderline Patient,” in a comparison of the type of devaluation that is characteristic of the narcissistic and the borderline patients.

**Severe Narcissism**

The severe narcissist represents the extreme end of the narcissistic spectrum. Such patients, because of the absence of even a modicum of conscience or guilt concerning their exploitative and often intensely aggressive (even violent) behavior, can seem repellent to the interviewer.
Infamous tyrants such as Hitler and Stalin, whose indifference to their murder of millions is emblematic of their inhumanity, have been labeled malignant narcissists. Whether or not this is diagnostically accurate, it is consistent with the popular image of these dictators. Severe narcissism does overlap with the antisocial personality, and in some cases, severely narcissistic persons are capable of chilling acts of cruelty, violence, and even murder.

Two themes dominate the psychopathology of severely narcissistic patients. One reflects serious ego deficits that manifest themselves in impulsivity, low frustration tolerance, and an inability to delay gratification. The other is the absence of normal superego functioning. This combination of deficits is at the core of the violent outbursts that can occur with these patients. The superego exerts no control over unbridled impulsivity. Narcissistic rage of an explosive nature may thus color the life of the severe narcissist. Narcissistic rage can be global and unlimited. Such rage is precipitated by imagined or real slights that these individuals experience when they are thwarted or contradicted in everyday life. Opposition to their wishes evokes the fantasy of obliterating the individual who does not succumb to their demands and who thus challenges their underlying, but tenuous, feeling of omnipotence. In extreme cases, this may actually lead to the murder of a partner or spouse, for which act the severe narcissist feels no remorse because, within his extremely pathological inner world, it is completely warranted. Massive superego pathology, combined with impulsivity, is at the core of the severe narcissist’s pathology and explains the absence of any feelings of guilt for his destructive actions.

**Differential Diagnosis**

The major differential diagnoses include borderline personality disorder, antisocial personality disorder, and bipolar spectrum disorders. Although there are relatively pure forms, it is not uncommon to see mixtures of narcissistic and borderline personality disorders.

Although in DSM-IV-TR the distinctions between the obsessive-compulsive patient and the narcissistic patient seem clear, in actual clinical work they are frequently blurred. This is particularly true in those patients with mixed character disorders who have both obsessive and narcissistic aspects. These distinctions are particularly important in the treatment of a patient who has both features, so that the clinician does not make the interpretation of an obsessive dynamic when, at that particular moment, a narcissistic dynamic is driving the patient’s behavior.

The first area of confusion is emotional isolation, which in the obses-
The obsessive patient may be confused with the cool detachment of the narcissist. The obsessive person utilizes the mechanisms of minimization, intellectualization, and rationalization to deal with his own unwanted emotional responses. "I was not angry at my boss," the obsessive patient stated after his work had been criticized. "I was not pleased; I may have been a trifle piqued; but I certainly was not angry." The narcissistic person is quite aware of the rageful response he felt in a similar situation and has already begun to devalue the other person as stupid. The obsessive individual lacks tact and sensitivity to the feelings of others and is often unaware that he has said something that bothered someone. If it is brought to his attention, he feels guilty or defensive and attempts through logic and reason to persuade the offended party that he or she should not feel hurt. On other occasions, the obsessive person notices that he said or did something that might have upset another person but he does not fully allow this to register in his mind, or if it does, he chooses to ignore it. The incident may later return to consciousness for further reflection or rumination. This does not happen with the narcissistic person, whose callous lack of concern for the feelings of others is genuine and is rationalized with an attitude of "that's how all people are; some are just better pretenders than others."

The obsessive person's pursuit of perfection differs from that of the narcissistic person, although this is perhaps one of the most difficult differential diagnostic features in understanding character pathology. The solution to the therapist's confusion lies in uncovering the latent object connection that is part of the perfectionistic pursuit or, in other words, understanding what unconscious motivation drives the behavior. What is it the patient expects to gain or lose—what conflict is involved in the perfectionistic drive? The obsessive person, when doing something perfectly, feels a sense of mastery, power, and control and anticipates praise or some positive reinforcement from his own internalized objects as well as from his parental figures. However, he feels the praise as an evidence of being respected—loved as a separate person even if he resents the feeling that he has to perform perfectly in order to win this respect. It is the firm sense of a separate identity that allows the obsessive individual to feel a genuine sense of accomplishment. This is due to his having internalized a good object image. He feels that he has been good and has lived up to his parents' perfectionistic standards. He deserves respect. At an unconscious level the obsessive person equates respect with love, and he believes that love must be earned. The narcissistic pursuit of perfection is a more exploitative event wherein the person is fulfilling a grandiose wish of his parent that will make the parent look good. The child is exploited as a device to
enhance the brilliance, beauty, and success of the parent. When the narcissistic child is admired or praised, he does not feel this recognition as a separate person but feels that he merely enhanced the perfection that his parent pursues relentlessly. His mission on earth is to make the parent look good or, if he chooses, look bad. Therefore, when a narcissistic person fails to achieve perfection, he feels humiliated, ashamed, degraded, and worthless. The obsessive person, on the other hand, is more inclined to wonder if he did it wrong, did not follow instructions or try hard enough, or in some other covert way was disobedient. This is because the obsessive always has contradictory impulses to be defiant and oppositional. This is where the doing and undoing rituals arise and why obsessive people are always plagued by self-doubt.

At times the narcissistic person will unconsciously fail deliberately in order to embarrass and humiliate the parent who humiliated them. It is a masochistic way of getting even, and the act is motivated by spite. The sweetness of spiteful revenge offsets the personal pain and embarrassment from the failure. This is a common mechanism in narcissistic, masochistic adolescents who fail in school to get back at the parent for only caring that the child attends a prestigious college.

Another aspect of narcissistic perfectionism is related to the amount of work the patient is willing to do in order to win praise. The obsessive person is aware that success requires both skill and effort, and he is willing to put forth the effort. The narcissistic person wants maximum recognition in exchange for minimal effort.

Both obsessive and narcissistic individuals have inordinate drives to obtain power and control over others. However, the former is always plagued by self-doubt and feels conflicted about the consequences for those he may have hurt or damaged in his own pursuit of success. The latter seems conflict-free about the intensity of his drives. Both types of patient may have inhibitions of work performance that can only be distinguished on the basis of differing concepts of the unconsciously imaged danger accompanying success. The obsessive person unconsciously views work in terms of the conflict between being obedient and accepted but with a consequence of feeling simultaneously submissive and weak and being naughty and defiant but with a consequence of feeling strong and independent. This dynamic is most apparent in the procrastination component of the obsessive person's work problem. At the same time, oedipal dynamics express themselves in the obsessive patient in his ambivalent attitude toward same-sex competitors whom he views as more powerful than himself. This takes the form of losing his assertiveness and not being able to finish off an opponent despite being close to victory. He wants to be boss so that he will not be con-
trolled by others. He wants his status, power, and control to be recognized by others. Typically, he assumes the responsibility that is appropriate to the power and sometimes even more than is appropriate. He will often complain about the responsibility but will feel great pride about it and be conscientious in discharging it. The narcissistic person desires the power in order to obtain the admiration of others and to be served by them, but he does not want the responsibility and looks for ways to push it off on some underling or otherwise to shirk it, sometimes under the guise of delegation of authority. This process becomes apparent when the narcissist delegates only the responsibility but never any of the glory that goes with successful achievement.

Consider the example of an obsessively indecisive graduate student. His ruminations involve “Which topic will please my thesis advisor the most and get me the best grade? Is there something I would really prefer to write about? Must I submit to his authority?” The narcissistic graduate student wonders which thesis advisor has the most power and glamour and wants a topic that will be flashy and bring him easy glory. A seeming exception to this principle occurred in the case of a narcissistic graduate student who chose to do her thesis in the Russian Department in preference to the German Department, where she had received higher grades and more encouragement as an undergraduate. However, the motive behind the choice was to spitefully demonstrate to the Russian Department that they had made a mistake about her brilliance, thereby vindicating herself and humiliating them. This can be contrasted with the obsessive person who argues over the meaning of a word and then goes to the dictionary. He wants recognition for his precision and implicit superiority, but his motive is not to humiliate his opponent. Paranoid personalities also wish to sadistically humiliate an adversary whom they feel has wronged them. The paranoid person wants recognition that he has been wronged, and he demands an apology—not just today, but again tomorrow, the next day, and on and on. However, if the offending party atones long enough, he eventually will be forgiven. The narcissistic character, on the other hand, merely writes off his adversary once and for all. The obsessive character, basically, wants to make up and will accept a sincere apology.

The histrionic character presents another difficult differential diagnostic dilemma. This type of patient is also attention seeking and may become quite flamboyant in order to remain the central focus of others. Narcissistic features are often mixed with histrionic character traits. The histrionic patient is quite capable of angry outbursts when these needs for recognition are frustrated. Nevertheless, this person is capable of genuine love and deep attachment to others. The histrionic patient has
more charm, warmth, and capacity to not always put her own needs first. Manipulation of others usually involves charm, flattery, and a presentation of pseudo-helplessness. In contrast, the narcissistic patient uses entitlement and aggressive assertions that are quite inconsiderate of the feelings of another person. An illustrative example of this distinction occurred when two patients became concerned about the clinician’s recent weight gain and what it might portend. The histrionic patient was genuinely concerned about the clinician’s health, and being an expert on diet programs, she plied the clinician with effective regimens. She was worried on his behalf. The narcissistic patient was affronted that the therapist had become fat. “How can I have a therapist who looks like you? This reflects so badly on me. Please see my personal trainer and lose some weight. I’ll pay for it.” Another differential diagnostic distinction occurs at the party where the histrionic patient is looking for her friends, whereas the narcissistic patient is looking for the “stars” who might be present while simultaneously thinking “Do I measure up to these people?”

The distinctions from borderline personality disorder are discussed in Chapter 10. The differential diagnoses between antisocial personality and severe narcissistic personality disorder are imprecise, and there is significant comorbidity. Crime families, for example, represent a deviant antisocial subculture. A member of such a group can have lasting friendships and alliances with other members, pursuing codes of ethics that are well defined although at variance with the mainstream of society. They are capable of great loyalty, particularly to their biological family members. The television and motion picture industries exploit a public fascination for these groups. They are often ruthless and kill easily, but this behavior does not make them narcissists, although it is clearly antisocial. The “family business” does not tolerate the excessively narcissistic members of the group who do not fit in with the group cohesiveness and goals.

Bipolar spectrum disorder is one of the emerging diagnostic groups in which considerable controversy exists. The former (DSM-II) hypomanic personality was described as grandiose, boastful, exuberant, overoptimistic, overconfident, ambitious, high-achieving, and self-assertive. This person may have brief episodes of depression. Despite these qualities, he is warm and “people friendly” and can participate actively in give-and-take relationships. He is not the inwardly envious, devaluing, and vindictive person who is characteristic of the narcissist.

When a narcissistic person voluntarily seeks treatment, it is often because of depression. Narcissistic injuries in the form of occupational failure or a significant loss of face in a failed relationship are the usual
precipitants. There is considerable overlap between dysthymia, narcissistic personality disorder (shy type), and masochistic personality disorder.

**Developmental Psychodynamics**

Healthy narcissism allows for a realistic appraisal of one’s attributes and ambitions, the ability to have emotional attachments to other people while recognizing their separateness, and the capacity to love and to be loved. The awareness of the separate existence and the feelings of other people is a crucial aspect of healthy narcissism. When normal development fails, one finds the psychological disturbances characteristic of the narcissistic personality, ranging from the self-involved and mildly entitled individual to the flagrant egocentricity of the severe narcissist, who will tolerate no external challenge to his conviction of superiority and omnipotence. It is thought that this variation in degrees of narcissistic pathology reflects the amount of parental emotional neglect and absence of empathy as well as parental exploitation that the child experiences during early development, leading to varying deficits in the sense of self.

The evolution of healthy narcissism and the capacity to differentiate self from other are thought to be contingent upon empathic parenting coupled with limit setting presented in a kindly manner. The small infant experiences the external world as an extension of the self, a state of being that persists in pathological narcissism. Self-object differentiation occurs as an incremental process that evolves through interactions, both gratifying and frustrating, with the caretakers and the outside world. Over time, under normal conditions, a psychological inner awareness of the separateness of the self from other develops. Simultaneously, the psychological internalization of an image of the empathic, nurturing caretakers occurs and becomes part of the child’s psychic structure. In a sense, this aspect of the external world becomes part of the child. This incorporation of representational aspects of the loving caretakers forms the underpinning for the child’s gradual acquisition of empathy for others, healthy self-regard, and solid sense of self.

A failure of empathic caretaking, in particular the absence of parental mirroring, throws the small child back upon the self, which is tenuous and, in the young infant, always in danger of fragmenting, a type of emotional “falling apart” that one sees regularly in babies and young children when they are distressed. Mirroring is a complex parent–child interactive phenomenon that involves the parents receiving communications from the infant or small child, registering them, transforming
them, imitating them, and reflecting them to the child. The parent echoes and elaborates the child’s sounds or actions such as babbling, cooing, or banging her high chair with her hand. This is an emotional experience for both parent and child. The playful mood is the best example in which parental imitation elicits gales of laughter from the child and further laughter from the parent. This interplay bears a resemblance to what occurs among musicians when the initial simple melody is picked up and elaborated by the full orchestra. It is a natural emotional music-making between the child and parent. The child’s experience interacts with the more psychologically highly organized parent, who integrates the child’s communication from his or her perspective, reflects it back to the child, and thus helps the child’s sense of self to evolve.

The message sent back to the child by the narcissistic or otherwise disturbed parent is not in empathic tune with the child’s communication. It becomes a confusing message because it has nothing to do with the child’s experience. Healthy mirroring implies a valid reflection of the child’s more primitive experience; it is the parent responding to the as-yet unrealized potential of the child. For example, the normal mother hears the child’s words in his babbling before he has language and will babble back in kind, thus reaching out to the infant who is struggling to communicate with the parent. The child’s sense of self-wholeness is endangered by the absence of what has been termed “the gleam in the mother’s eye,” a poetic expression of the caretaker’s delight in the infant’s assertiveness and self-display. A heightened terror of fragmentation of the self is thought to arise from the caretaker’s inability to respond approvingly to the demonstrative behavior of the infant. One theory claims that this failure also leads to the child’s self-development becoming arrested, which continues into the adult life of the narcissist. The sense of self remains deficient, and an unconscious terror of potential self-fragmentation dominates the psyche, leading to compensatory defensive fantasies of grandiosity and omnipotence: “I am all-powerful. I cannot be destroyed.” A state of inner emptiness and warded-off feelings of inadequacy and inferiority is also thought to be a consequence of these parental deprivations. “I have not been loved; therefore I am not lovable.” The overvaluation by the narcissist of physical beauty, wealth, and power is a manifestation of the often desperate compensatory need to find external props that will reassure him that “I am the best, the most beautiful, the richest” and keep at bay the dread of confronting inner emotional poverty. This may begin when the child says, “Me do it, me do it,” and the parent replies, “You can’t do that; I’ll do it.” Except when the action is potentially dangerous, the more empathic parent says, “You can do it; let me help you.”
Narcissists are commonly envious. From a developmental viewpoint, envy should be distinguished from jealousy. Jealousy is the desire to possess another person and triumph over a rival. It has a three-person quality and is typical of the oedipal period of development—the child's unconscious wish to have the opposite-sex parent to himself and remove the same-sex parent as a competitor. Envy occurs earlier in development and has a two-person nature. The child envies the parent for some quality he or she possesses—strength, size, power—that the child would like to have. In its more primitive manifestations, found in the narcissistic patient, envy can carry with it the active wish to destroy the person who arouses envious feelings in order to remove the source of feeling inferior.

The narcissistic patient usually can recall incidents in which one or both parents shamed the child in lieu of punishment. One patient recalled at the age of 4 or 5 hearing his mother say, "Young man, you should be ashamed of yourself." Such events occurred with regularity and instilled a deep sense of shame. This mother was narcissistic and viewed the child as an extension of herself. The child's imperfections were an exposure of her imperfections, about which she felt terribly ashamed. She frequently told her son, "You did that deliberately to humiliate me!" leaving the child feeling hurt, inadequate, and unable to understand the mother's response. Developmentally, the child experiences shame prior to acquiring a capacity to experience guilt. The child is ashamed when he is caught not living up to parental expectations. The more the parent humiliates the child or withdraws love, the more difficult it becomes for the child to internalize the parental values. The child needs to experience love-based criticism from the parents—that is, parents who are more concerned with the child's feeling than what other people will think of them as parents. When the child feels loved, he will internalize the parents' values and will feel guilty when he fails to live up to these values. This maturational step is not accomplished by the narcissistic person, who feels ashamed and humiliated when his mistakes or inadequacies are exposed by others. If he is not caught, he does not feel guilty. It is this same superego deficit that causes his low self-esteem, because he is unable to win the approval of his unloving internalized parents. The capacity to experience guilt has built-in mechanisms for the person to forgive himself. This is accomplished by confession and atonement, with the motive of obtaining forgiveness. The mature adult has learned how to manage guilt feelings and feels secure enough to apologize, to make amends, and to learn from the experience. In the small child, feelings of shame may occur concerning normal bodily functions if the child is scolded for accidents. The response to
shame is to hide. This persists in the narcissistic adult, who will go to
great lengths to disguise and thus not acknowledge misbehavior in
order to escape exposure. Shame carries with it the related subjective
experiences of humiliation and embarrassment, again all part of the
child's experience of being small, losing control of his bladder or bow-
els, feeling weak and inferior, and being exposed and criticized. Shame
is predicated on the expectation of exposure. It is wetting one's pants in
public and being observed in the act. If the accident can be hidden, there
is no shame. Shame results from being observed and thus humiliated by
the observation of the other. If the narcissistic person can disguise or
hide his sense of inadequacy, he will avoid the painful affect of shame.
This propensity to hide perceived inadequacies with their potential for
humiliation will inevitably distort the clinical interview with the narcis-
sistic patient. The narcissist will go to great lengths to avoid revealing
aspects of his history and present life that could recapitulate the expe-
rience of shame with the clinical interviewer.

One or both parents of the future narcissist tend to have prominent
narcissistic features in their own character structure. One woman vividly
recalled being criticized in a humiliating fashion by her mother, an arro-
gant woman who believed that she was always right. The patient de-
scribed concluding, at a rather young age, that she was smarter than her
mother. By identifying with her mother, she neutralized her mother's
power to hurt her. In the process, she became contemptuous not only of
her mother but also of all people whom she deemed less intelligent than
herself.

Another psychodynamic contribution to the development of the shy
narcissist is from the parents who consider their child to be perfect and
overlook his mistakes or deficiencies. He becomes the parents' narcis-
sistic projection of their own grandiosity. One patient said, “When I
make a mistake, I try to cover it up. If I can’t cover it up, I blame some-
one else. And if all else fails, I might admit that I did it, but I make up
an excuse. I didn’t feel I could live up to my parents’ expectation of
greatness. I always felt I had to fake it, that I was a fraud.” The ther-
pist’s question that elicited this material was, “How do you feel when
you discover that you have made a mistake?” In this case, the parents
were never critical, settling for whatever the child did as “great.” This
person's inner shame developed without the parents ever telling him he
should be ashamed of himself.

Failures of parental empathy occur throughout the entire develop-
mental period. Consider the case of an 8-year-old girl who was using
the family bathroom. A visiting aunt wanted to use the bathroom. In-
stead of knocking on the closed door, she asked the child’s mother if
there was anyone in the bathroom. The mother replied, “It’s only Jane. Go right in; she won’t mind.” The child felt deeply humiliated, as though she were a nonperson.

Narcissism changes throughout the life cycle. As the narcissistic and emotionally deprived child grows and enters the world of school and peer relations, the already-present compensatory sense of superiority and entitlement may be perniciously fostered by parents. “This is my due; I am special and should be treated as such” can be pathologically reinforced by the parents’ projected belief in the child’s specialness. “My child should not have to conform to conventional strictures on behavior but should be given special attention.” This parental sanction of entitlement in the school-age child can be a major contributing factor to the hypertrophied self-importance and smugness seen in the narcissistic adult. The child mirrors the parents’ narcissism.

All adolescents, faced with the startling physiological changes and body alteration of puberty, respond with narcissistic patterns of adaptation. Conflicted about the upsurge of sexual desire and the all-too-obvious physical changes initiated by the onset of puberty, they readily become preoccupied with their appearance and acutely sensitive to how they are viewed by their peers. They are often self-involved, hypersensitive to criticism, prone to feelings of humiliation, and thus emotionally vulnerable, just like the full-blown narcissistic adult. Shame often dominates their feelings about bodily functions and sexuality. These narcissistic concerns, in more extreme cases, play a part in the development of anorexia-bulimia in some teenagers. Generally, narcissistic adolescent bodily and social preoccupations will fade with the passage of time, but in the teenager who has experienced emotional deprivation as a child, they may carry over into adulthood as another aspect of narcissistic pathology.

MANAGEMENT OF THE INTERVIEW

The narcissistic patient is often reluctant to seek professional help because to do so threatens his grandiosity. The precipitating reason for the consultation is often because his spouse demands that he obtain help if the marriage is to be saved or because he has become depressed after some job or career crisis. Another common presentation is the conviction by the patient that he is not appreciated by his colleagues or peers, who do not recognize his brilliance and unique contribution to their profession or organization. Unconsciously, the patient expects that the clinician will show him how to change the perception of others to
admire his achievements. Another precipitant that brings the narcissis-
tic patient to the clinician may be a profound midlife crisis. This results
from a bitter awareness that his grandiose fantasies and goals for him-
self have not been and may never be met. This awareness often leads to
a feeling of being disconnected from others and deeply dissatisfied with
life in general.

According to Kohut, there are certain principles that apply to the
early interviews with the narcissistic patient. In an empathic manner,
acknowledge the phase-appropriate demands of the grandiose self. It is
a mistake to tell the patient in initial interviews that his demands on
others are unrealistic. It is important to allow an idealizing transference
to develop, because it will, in time, lead to a projection of the patient’s
ego ideal onto the therapist. This process may make the patient feel in-
significant by comparison, but it sets the stage for the patient to identify
with a figure of authority who does not behave narcissistically. The
therapist must be sensitive to every slight or narcissistic injury that he
inadvertently inflicts on the patient and must not behave defensively. If
an apology is appropriate, it will set an example of something of which
the patient is incapable. These exchanges cannot be abstract but must be
expressed in real time, using personal pronouns and not labeling them
as transference. This recommendation is true even when the patient
states, “You are treating me the same way that my mother did.”

In initial interviews, some transference indulgence to a limited de-
gree can be useful. It is helpful to link the patient’s behavior with un-
derlying feelings, realizing that for this patient only real things have
meaning. This includes being able to change an hour or refusing or
granting a request. The patient may ask questions about the clinician
that initially can be answered, provided the therapist then asks the pa-
tient about the significance of what he has learned. This helps to open
up a defensive patient. If the patient then shares this information with
someone else, the therapist can explore how that made the patient feel.
It might be helpful to tell the patient, “It was not my intention that you
would share that with someone else.” This helps the patient see that he
used a shared moment to enhance his status with someone else or to
elicit envy. Threats to the idealizing transference lead to depression,
whereas threats to the grandiose self lead to rage.

A talented orthopedic surgeon sought psychiatric consultation after he
had impulsively resigned from the medical center where he had been
employed. His resignation, however, had not been preceded by his ob-
taining another position, and now he was unemployed. He very reluc-
tantly agreed to see the clinician, mainly at the urging of a colleague, one
of the few whom he trusted, who was concerned about his friend's excessive drinking and black moods since he had left his job. "They never appreciated me even though I am one of the nation's experts on hip replacement and knee reconstruction. The administration never made my operating room schedule a priority. They were always shuffling my O.R. nurses around. They didn't realize what I was contributing to their institution." The institution in question was a renowned teaching hospital staffed by a galaxy of prominent physicians, of whom the surgeon had been one among many. The final straw was the hospital annual benefit. "I was given a lousy table, and the Chairman of the Board of Trustees acted like he didn't know who I was."

The feeling that he was not given his proper due extended into his private life. Currently divorced, he had been married three times. "They just didn't get me," he claimed when asked about his previous marriages. "I'm really very sensitive, and they were all self-involved. My last wife wouldn't offer to give me a back rub after an exhausting day of surgery. I had to ask her—unloving bitch. That's why I left her. Honestly, I don't think you can have any idea of what I have been through. I have always given so much of myself and have never really been appreciated or cared about." The interviewer became aware that he was being cast in the role of another in a long line of unappreciative, uncaring people. Using this self-observation the interviewer commented, "There seems to be a consistent history of people not recognizing your emotional needs or your achievements. When did this begin?" "With my parents of course. My father was never home. He was out philandering. My mother was never home either; she was always at one of her ladies' lunches or charity events. The help didn't give a shit about me, and then I was shipped off to boarding school at a ridiculously young age. That was a nightmare. I was bullied and abused. No one cared about me or what I was feeling. I was so little." The patient who had begun the interview in an arrogant and overbearing manner, filled with contempt for other people, had been transformed into the sad, hurt child whom the interviewer could now experience as touching and for whom he felt genuine empathy for his troubled and unhappy state.

TRANSFERENCE AND COUNTERTRANSFERENCE

An underlying fragile sense of self dominates the psychology of the narcissistic patient and dictates the parameters of the clinical interview. Paradoxically, although the narcissist seems so self-involved and oblivious to the feelings of others, he is acutely sensitive to any wavering of the interviewer's attention and reacts angrily to any lapse that may occur. "Why are you looking at the clock? Am I boring you?" exclaimed a narcissistic patient as the first interview approached its end. There was an element of truth in this accusation. Feeling bored in response to the narcissist's egocentricity is a common reaction for the clinician, who may
have the feeling that his function is only that of an appreciative audience. There is often no sense of being engaged in a collaborative enterprise designed to bring some understanding to the troubles that brought the patient to request a consultation in the first place. Considerable effort may be required to remain engaged and not drift off into one’s own thoughts, reflecting the same self-preoccupation as the patient.

Transference asserts itself in the clinical interview with the narcissistic patient right from the beginning. The patient struggles to avoid a feeling of humiliation concerning his experience consulting a mental health professional. The need for psychiatric evaluation is often perceived by the patient as evidence of a defect or failure of self. This frequently invokes shame and anger at the putative humiliation the consultation represents:

When asked by the interviewer, “What brings you to see me?” one patient replied, “I think you should see my girlfriend and her mother, not me. They are the problem. Her mother is incredibly intrusive, and my girlfriend is insensitive. Even though she went to Yale, I think she’s dumb. They are the issue, not me. I’m only here to humor them.” The patient then revealed that his girlfriend, after 5 years of living together, had threatened to break up with him. “It’s not easy to reveal these problems,” replied the interviewer, empathically acknowledging the feeling of humiliation that consumed the patient. “It’s not easy at all, especially since she and her mother should be your patients, not me,” the patient responded.

This intervention allowed the interview to go forward and diminished the patient’s paranoid feeling of a consultation under duress. He had made the appointment in response to a threat of losing his girlfriend, and he responded with conscious panic and humiliation. Gradually, as the interview progressed, the patient expressed a fear of becoming depressed if he lost his girlfriend, a hopeful sign of human connection that could be brought into play in ongoing therapy.

Hypervigilance and excessive scrutinizing of the therapist are characteristic. This is part of the defensive structure of the narcissistic person, and it is driven by mistrust and fear of humiliation. This behavior is often misinterpreted as a competitive transference. The therapist finds it easier to see the patient in that framework rather than to see that the patient does not wish to accept him as a separate person whom he values. Therefore, it is more accurate to interpret the patient’s attitude as devaluing rather than competitive. This is the patient who, when the therapist has to cancel a session, will respond by canceling the following two sessions.
One patient, who had conscious feelings of superiority and feelings of contempt for others, sent her clinician a bad check. Several sessions passed and no mention was made of the returned check. Finally, after 3 weeks, the clinician showed the patient the returned check. “Oh, that,” replied the patient. “My bank must have screwed things up; they sent me a notice about a couple of those. I don’t know what happened.” The therapist remarked, “You haven’t brought it up.” Now the patient lied and said, “I didn’t realize that you got one.” The therapist remarked, “You are blaming the bank, I am more interested in how it makes you feel.” “Oh,” the patient continued, “it’s no big deal, one check was yours and the other was to the phone company.” The clinician replied, “You sound very defensive. Is there a feeling of embarrassment that you have?” “I would say so; I don’t make mistakes like that,” the patient responded.

This episode illustrates how shame makes the patient hide. For this person, an apology would have intensified her feeling of humiliation and revealed her fragile self-concept. She did not understand that a genuine apology can bring people closer together through the process of forgiveness and expiating one’s guilt. This process was explored with gentle guidance from the therapist. Further discussion of this episode enabled the therapist to point out the haughty, arrogant, defensive position that indicated the patient’s inability to expose her deep shame. It was hiding this shame while ignoring her lack of concern for the other person that intensified her feelings of alienation and aloneness.

The narcissistic patient who is better defended and less primitive may not experience the psychiatric consultation as a humiliation. Instead, he is intent on charming and seducing the interviewer. He is delighted to discuss the complexity and difficulty of his life, provided the interviewer remains a mirror who reflects but does not disrupt the flow of his narrative. He is not humiliated by being in the clinical situation but sees it as another opportunity to display himself. The transference here is a mirroring one. The clinician is merely a reflector. This desire for a mirroring experience continues from infancy, when it would have been appropriate for the caretakers to reflect back to the child their appreciation and love for his exhibitionistic display.

The second type of transference commonly found with the narcissistic patient is the idealizing one. Simply by listening to the narcissist’s story, the clinician is invested with the grandiosity that permeates the patient’s subjective life. “You are so sensitive and brilliant,” stated a narcissistic patient in the second interview, startling the clinician, who had been unable to get a word in edgewise or even to interject clarifying questions in the first interview. Rather than challenging this unwar-
ranted endorsement of her brilliance and sensitivity, the clinician kept quiet and listened. Not confronting the idealizing transference in the early interview situation is prudent, because to do so disrupts the patient’s fragile sense of self. The urge for the clinician to interpret the idealizing transference out of a sense of guilt or embarrassment may lead to an abrupt termination of the therapy because it threatens the narcissist’s fragile sense of self. The clinician’s discomfort with the patient’s idealizing transference may stem from her own residual unconscious narcissistic wishes to be loved and adored or from a wish to ward off later devaluation.

The countertransference response to the narcissistic patient that requires the greatest vigilance is the tendency to inwardly disparage the patient. Because of his grandiosity, exhibitionism, envy, indifference to the feelings of others, propensity for rage, and sense of entitlement, he may readily engender a hostile and contemptuous response in the interviewer, one that makes the patient seem alien. Such a response does not recognize the underlying and pervasive suffering of the narcissistic patient, which is thinly masked by his egocentricity. The inner suffering is profound and at its extreme includes a fear of self-fragmentation, a panic of falling apart. All narcissistic patients, including those with milder illness, suffer periodically from a sense of inferiority, emptiness, and frightening aloneness. The defensive, compensatory behavior in response to this inner state is ultimately masochistic because it drives people away, confirming their isolation in the world.

The interviewer must tolerate the experience that he does not exist as a separate person in any meaningful fashion for the patient and must be able to use this unpleasant experience as an entrée into understanding the bleak and frighteningly empty inner psychic world of the narcissistic person. Such self-monitoring on the part of the interviewer will engender an empathic and compassionate response to these troubled individuals and enable a therapeutic process to go forward. As an example, after several sessions, an interviewer sensed a moment of vulnerability in the patient as a very brief reaction to an empathic comment. The patient abruptly flushed and excused himself as he rushed into the therapist’s bathroom. The clinician heard the water running because the patient had not even bothered to close the door. After a minute or two, the patient returned. He explained, “I felt this sudden flush of tingling in my face, and I just had to splash some cold water on it. Now what were we talking about?” The interviewer got the message and allowed the patient to pursue another topic, hoping to analyze the experience at a later date when the patient felt stronger.
Another narcissistic patient began the second interview with a female clinician by saying, "I don't know why I came back a second time. Sigmund Freud you're not. In fact you seem rather simplistic, not to say dense." "What bothered you so much last time?" responded the interviewer. "You kept challenging my interpretation of the events that led to my losing my job. As if there were any other explanation than mine."

The interviewer was in a delicate position. The facts surrounding the patient's dismissal from his job made clear that it was directly related to his high-handed behavior at work and his contemptuous treatment of his superiors as fools in much the same manner that he was now attacking the interviewer. Nonetheless, the interviewer was aware of a failure of her empathy in the first interview. She had been put off by the patient's self-serving explanations and complete obliviousness to his own arrogant and overbearing behavior. He had complained about being surrounded by morons and felt that it was his mission to enlighten his fellow workers concerning their blatant stupidity. He contended that he was infinitely more farsighted and brilliant than anyone around him in the workplace. The interviewer in response had engaged in a dialogue questioning the patient's view of the events that resulted in his dismissal, a direct result of her negative countertransference response. This time the interviewer adopted a more neutral attitude predicated on an awareness of the narcissistic injury and shame the patient had suffered in being fired. "These events have been very hurtful to you, especially as they seem to have come out of nowhere." Without agreeing with the patient's interpretation of these events, or reacting to his personal attack on her, the therapist supported him by understanding his feeling of injustice, shame, and humiliation. This allowed the interview to proceed and led to the patient recounting a long history of personal slights and lack of appreciation from others that he suffered throughout his life—all a consequence, in his opinion, of the envy that his brilliance and perspicacity aroused in those around him.

An alternative approach would be to ask the patient for a detailed account of how he originally obtained this job and his progress with it. Then one can ask, "How were you notified?" and comment in an empathic tone, "What kind of excuse did they give you?" This can be followed by an inquiry regarding the patient's response. This approach allows more details to emerge. A comment about life not being fair is better than one that sounds more appropriate for a small child, in effect, "poor baby."

A patient commented in the second interview that he felt anxious because of an impending social function where he was expected to make a toast. "I really can't speak in front of a group of people. I'm afraid I'll make a fool of myself. I'll say something stupid—or worse, I won't be able to think of anything." The interviewer asked, "Do you feel the people are coming to judge your performance more than to enjoy the
celebration of your son’s wedding?” With downcast eyes, the patient responded, “I guess I do.” The interviewer continued, “Are you pleased with his choice, and are you proud of your son?” “Very much,” the patient said. “And are you pleased that people are coming to the party?” the interviewer asked, to which the patient replied, “I appreciate them coming, but it would not have occurred to me to tell them that. I should write this down.” The interviewer then replied, “You might want to rehearse it out loud until you like the way you sound.” The following week, the patient reported considerable satisfaction with his behavior and his speech at his son’s wedding and noted that his son and some old friends asked what had come over him. He felt understood but still surprised by his success.

CONCLUSION

The ongoing psychotherapeutic treatment of the narcissistic patient is beyond the purview of this book, and the reader is referred to standard texts on treatment. Most narcissistic patients, however, can benefit greatly from well-conducted psychotherapy. They are imprisoned by their arrested development, but careful psychotherapy, predicated on a high degree of empathy for their inner anguish, can break the intrapsychic ice and restart the process of emotional growth.