

Part II

TYPES OF CHARACTER ORGANIZATION

INTRODUCTION TO PART II

Each chapter in this section covers a major character type. I have chosen these types on the basis of the frequency with which they are encountered clinically and on the basis of my own clinical familiarity and confidence working with them. As I noted in the [Preface](#), some personalities that I do not cover in this section are depicted in the *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006).

Order of presentation is arbitrary, but overall, I have started with the least object related and ended with individuals who tend to strike therapists as powerful in their attachment, even though their specific attachment style may be problematic. With each personality I consider (1) drive, affect, and temperament; (2) adaptive and defensive ego functions; (3) early relational patterns that contribute to the development of the personality, become internalized, and repeat in later relationships; (4) experiences of the self, including conscious and unconscious ways one sees oneself, along with the ways one seeks self-esteem; (5) transference and countertransference outcomes of internal representations of self, others, and self-other patterns of interaction; (6) implications for treatment; and (7) considerations of differential diagnosis.

RATIONALE FOR CHAPTER ORGANIZATION

The first four categories I have taken from Pine (1990), who has summarized drive, ego, object relational, and self aspects of individual psychology as follows:

Broadly speaking, under these four terms I am referring, respectively, to the domains of (a) drives, urges, wishes; (b) defense, adaptation, reality testing, and defects in the development of each; (c) relationships to significant others as experienced and as carried in memory; with whatever attendant distortions such experiences and memories may entail; and (d) subjective experience of self in relation to such phenomena as boundaries, esteem, authenticity, and agency. (p. 13)

Like Pine, I see these four perspectives as implicit in the psychoanalytic tradition and as useful for sorting out different aspects of psychological complexity.

I have added affect to Pine's first domain (cf. Isaacs, 1990; Kernberg, 1976; Spezzano, 1993; Tomkins, 1962, 1963, 1991, 1992). Because Freud subsumed emotion under drive (see Solms & Nersessian, 1999), a focus on affect per se has been slow to come to analytic theorizing. In a 2000 survey, however, Blagys and Hilsenroth found that psychodynamic clinicians consider work with affects to be definitional of their orientation. Analysts have long noted the therapeutic superiority of emotional over intellectual insight (see J. G. Allen, 1980); more recently, many theorists have put affect at the center of human psychology and the clinical process (e.g., Chodorow, 1999; Fosha, 2000, 2005; Maroda, 2010; D. Shapiro, 2002).

There have been countless scientific studies attesting to the powerful operation of unconscious affects (see Westen, 1999). Research during the last two decades into early experience and brain function (e.g., Damasio, 1994; Lichtenberg, 1989; Panksepp, 1999; Solms & Bucci, 2000) supports the need to differentiate and comprehend these implicit feelings if we are to understand personality differences. Rainer Krause's work (e.g., Anstadt et al., 1997) suggests that we all have a characteristic facial affect pattern—an emotional “fractal,” or type and sequence of affective expression that is our unique emotional signature. It has thus become clear that stable personality differences include distinctive affect configurations.

I have also included temperament with drive and affect. The significance Freud attached to innate individual differences in areas like direction and strength of drive look prescient in the light of contemporary genetic and neuroscientific findings and in the aftermath of decades of scholarship about temperament (Kagan, 1994). Because therapy orients itself to what is modifiable, a clinician may tend not to think much about inborn “givens,” but what is hardwired is still valuable to understand. Appreciating someone's constitutional endowment contributes to reasonable goals and allows us to help a client accept and make new adaptations to what cannot be changed.

The next two topics under each type are intended to illuminate the interpersonal style of someone with that psychology and to suggest components of effective therapy with such a person. I discuss countertransference issues for both diagnostic and therapeutic reasons. Our emotional reactions contain important diagnostic information—often the only clues (especially in more disturbed patients) for differentiating between two character types with contrasting therapeutic requirements. In addition, countertransference information may prepare us for what we are going to feel working with any client; we can then improve our chances of handling our feelings effectively. I have included in these sections some ideas about passing what control–mastery

theorists would regard as characteristic “tests” of patients with different types of personality (Weiss, 1993).

Finally, I have included a differential diagnosis section to alert readers to possible alternatives to what may seem an evident personality organization, especially when such differentiations have important therapeutic consequences. It can be disastrous, for example, to misunderstand a hysterical woman as fundamentally narcissistic, or a narcissistic man as essentially obsessive, or a person with pervasive dissociation as schizophrenic. And yet all of these mistakes are made all the time because the DSM checklist approach to diagnosis lends itself to such errors.

CHARACTER, CHARACTER PATHOLOGY, AND SITUATIONAL FACTORS

The following descriptions include both disturbed and healthy versions of each character type. Everyone has regularities of experiencing and coping that constitute a personality. In most of us, it is not “disordered.” We all have features of several personality styles no matter which tendencies are paramount in us. Many people who do not fit neatly into one category are adequately described as a combination of two types of organization (e.g., paranoid–schizoid, depressive–masochistic). Assessment of someone’s character structure, even in the absence of a personality disorder, gives the therapist an idea of what will be assimilable by the client and what style of relatedness will catalyze the therapist’s efforts to help. Even though no one’s psychology corresponds point for point to a textbook description, most of us can be located in a general area that gives a clinician some orientation toward how to be therapeutic.

Dynamics are not pathology. It is reasonable to infer character pathology or personality disorder only when a person’s patterns are so stereotypical that they prevent psychological growth and adaptation. An obsessive man organizes his life around thinking, finding self-esteem in creative acts of thought such as scholarship, logical analysis, detailed planning, and judicious decision making. A pathologically obsessive one ruminates unproductively, accomplishing no objective, realizing no ambition, hating himself for going in circles. A depressive woman finds satisfaction in taking care of others; a pathologically depressive one cannot take care of herself.

In addition to distinguishing between personality and personality disorder, it is important to distinguish between character and responsivity. Certain situations elicit aspects of anyone’s personality that may be latent under other circumstances: losses bring out one’s depressive side; battles for control breed obsessive ruminations; sexual exploitation evokes hysteria. The therapist should be careful to weigh the relative impact of situational factors and characterological ones. People who are in ongoing, unrelentingly stressful situations may look character disordered by

external criteria, but their patterns may be more situational than internal. For example, employees or students in “paranoiagenic” institutional surroundings may seem to have stable traits that meet the DSM criteria for paranoid personality disorder, and yet those traits may disappear when they leave the setting and are no longer feeling humiliated, helpless, and unsafe (cf. Kernberg’s [1986, 2006] observations about paranoiagenesis in psychoanalytic institutes).

A Chinese student who was seeing one of my colleagues had numerous narcissistic preoccupations: She was acutely sensitive to how she was perceived, spent considerable energy on maintaining her self-esteem, suffered envy of American students to whom everything seemed to come easily, and worried constantly about whether she “fit in.” The genuine warmth with which she related to her therapist, however, and the affection in his countertransference, belied a conclusion that she had an essentially narcissistic personality. The stresses of adapting to a new community had exacerbated the latent concerns about acceptability, identity, and self-esteem with which anyone would struggle if culturally displaced. In addition to illustrating a caveat about confusing personality with reactivity, this example points to the critical value of subjective data.

LIMITS ON PERSONALITY CHANGE

Clinical experience suggests that although personality can be substantially modified by therapy, it cannot be transformed (the drive-theory homily for this observation was “You can change the economics but not the dynamics”). That is, a therapist can help a depressive client to be less destructively and intransigently depressive but cannot change that client into a hysterical or schizoid character. People maintain their “inner working models” (Fonagy, 2001): core internal scripts, conflicts, expectations, affects, and defenses. Yet with new experience and insight they may vastly expand their sense of agency and realistic self-esteem. The increased sense of freedom comes from mastery and choice in behavior that previously was automatic; the self-acceptance comes from understanding how they got their particular combination of tendencies. Whether or not a therapy contract includes an agreement to try to modify character, an appreciation of it may facilitate psychotherapy.

I have wanted this book to be comprehensive, but not so much so that it would weigh down the reader’s book bag, expense account, or fortitude. This section gives in-depth descriptions of psychopathic, narcissistic, schizoid, paranoid, depressive, hypomanic, masochistic, obsessive, compulsive, hysterical, and dissociative personalities. As I noted previously, there are many other themes around which personality can be organized, but these are the configurations I know best. It is my impression that most of the personality types I have omitted are seen more commonly as melodic variations than as symphonic themes. For example, while people whose character is

fundamentally and centrally sadistic are not unknown, they rarely come voluntarily to therapy. We are more likely to see sadism as part of another clinical picture, such as psychopathy or dissociation. Some people are passive-aggressive at the level of character, but more commonly, passive-aggressive tendencies are ancillary to other dynamics, including dependent, obsessive-compulsive, paranoid, and masochistic trends.

Psychopathic (Antisocial) Personalities

I begin discussing the typological categories of personality organization with what are probably the most unpopular and intimidating patients encountered in mental health practice, those who are essentially psychopathic. I am following Meloy (1988) in using the older term for this personality type. The term “antisocial” looks at the phenomenon from the outside, at what is externally visible, with an emphasis on the social consequences of this psychology, whereas I try here to explore the subjective experience and internal dynamics of psychopathic people.

Research has supported Kernberg’s (1984) concept of a range of narcissistic conditions (disorders of the self), with extreme psychopathy on the far end (e.g., Gacano, Meloy, & Berg, 1992). Robert Hare (e.g., Hare et al., 1990) distinguishes true psychopaths from people with antisocial tendencies, using the term “psychopath” to denote only a fraction of the larger spectrum. This is a valuable distinction for research, and one that has had vital practical outcomes such as identifying job applicants who would be disastrous employees. For purposes of discussing dynamics that pervade the antisocial spectrum, however, I use the adjective “psychopathic” more loosely, as equivalent to “antisocial,” and the noun “psychopathy” for the whole antisocial range. But unlike my practice in 1994 and in deference to Hare’s differentiation, I use the noun “psychopath” only for the extreme version of this psychology, and I avoid using “sociopathic,” as that term now suggests a dated distinction.

Although there is overwhelming evidence that extreme psychopaths are not treatable (M. H. Stone, 2000), it is possible to have a therapeutic influence on many individuals with antisocial tendencies. People whose personalities are structured along psychopathic lines range from extremely psychotic, disorganized, impulsive, sadistic people like Richard Chase (Biondi & Hecox, 1992; Ressler & Schactman, 1992), who randomly murdered, dismembered, and drank the blood of his victims (in the delusion that his own blood was poisoned, and he needed it to survive), to urbane, polished charmers like the characters depicted by Babiak and Hare (2007) in their chilling work on American corporate psychopaths: *Snakes in Suits*. The psychopathic continuum loads heavily in the borderline-to-psychotic direction, because conceptually, the diagnosis refers to a basic failure of human attachment and a reliance on very primitive defenses.

With Bursten (1973a), however, I would argue that there are people in the higher ranges whose personalities show more psychopathy than any other features and who are reasonably

construed as high-level antisocial personalities. Such people have enough identity integration, reality testing, and capacity to use more mature defenses to be considered neither borderline nor psychotic, but their core ways of thinking and acting show an antisocial sensibility. Some highly successful people have had an essentially psychopathic outlook; assuming good-enough ego strength, ruthless indifference to others can make competitive achievements easier than they are for those who are capable of loyalty and thoughtfulness.

In 1939, Henderson differentiated between “passive–parasitic” psychopaths and aggressive violent ones. An example of the former would be a developer of a Ponzi scheme who seems to have a warm family and good friendships (at least until the scam is exposed). As a society, we seem to be more taken aback by this more subtle version of psychopathy than by its more aggressive manifestations, but the exploitive orientation toward others is the same. Bursten’s (1973a) criterion for diagnosing a psychopathic person, that his or her organizing preoccupation is “getting over on” or consciously manipulating others, captures the essence of psychopathic psychology. Conceived this way, the diagnosis of characterological psychopathy has nothing to do with overt criminality and everything to do with internal motivation.

DRIVE, AFFECT, AND TEMPERAMENT IN PSYCHOPATHY

The fact that infants differ in temperament from birth (something any parent with more than two children always knew) has now been well established scientifically (Kagan, 1994; Thomas, Chess, & Birch, 1968). Some areas in which infants have demonstrated innate variability include activity level, aggressivity, reactivity, consolability, and similar factors that might tilt development in a psychopathic direction. Early studies of twins and adoptees (e.g., Vandenberg, Singer, & Pauls, 1986) concluded that people who become antisocial may have more constitutional aggressivity than others. In the years since the first edition of this book, there has been an explosion of brain research showing that our prior assumptions about the separability of what is constitutional and what is learned was naive: Genetic dispositions can be skewed by early experience, genes can be turned on or off, brain chemicals are altered by experience, and everything interacts. In a well-designed longitudinal study, Caspi and colleagues (2002) found that people with a variation in the expression of a gene that breaks down norepinephrine and related neurotransmitters (the monoamine oxidase A [MAOA] variation that can have permanent effects on the X chromosome), are much more likely when subjected to maltreatment to develop violent and antisocial patterns (see Fonagy, 2003; Niehoff, 2003).

Early neglect, abuse, and maltreatment can affect the development of the orbitofrontal cortex, which seems to be the moral center of the brain (Damasio, 1994; Martens, 2002; Yu, 2006). Thus, the biological substrate for the high levels of affective and predatory aggression in antisocial people may not directly implicate their genetic heritage, but may still be essentially “hardwired” by the interaction of experience and genes. Antisocial personalities have low serotonin levels, of whatever

origin (Coccaro, 1996), and diagnosed psychopaths have remarkably low reactivity of the autonomic nervous system (Intrator et al., 1997; Lykken, 1995), a fact that may explain their sensation-seeking and long-noted “failure to learn by experience” (Cleckley, 1941, p. 368).

Louth, Williamson, Alpert, Pouget, and Hare (1998) found that psychopaths have anomalies in the brain circuitry that underlie linguistic and affective processes, suggesting that extremely antisocial people have not learned about feelings in the relationally grounded way that most of us do. Instead, they acquire emotional speech as a kind of “second language” that is used to manipulate others rather than to express inner states. Psychopathic individuals have poor affect regulation and a higher-than-average threshold for pleasurable excitement (Kernberg, 2005). Whereas most of us can get emotional satisfaction from good music, loving sex, natural beauty, a clever joke, or a job well done, they may need a sharper, more jolting experience to feel alive.

As for the main feelings of psychopathic people, it is hard to specify them because of their inability to articulate emotion. They act instead of talking. They seem to have a sense of basic arousal without the sense of having specific affects. When they do feel, what they experience may be either blind rage or manic exhilaration. In the section on relational patterns in this chapter, I suggest some reasons for what Modell (1975) first described as a “massive affect block.” One way the treatment of psychopathic individuals differs markedly from therapy with people with other personalities is that the clinician cannot expect to make an alliance by reflecting the client’s presumed feelings.

DEFENSIVE AND ADAPTIVE PROCESSES IN PSYCHOPATHY

The primary defense in psychopathic people is omnipotent control. They also use projective identification, dissociation, and acting out. The need to exert power takes precedence over all other aims. It defends against shame and, especially in brutal psychopaths, distracts others from seeing the sexual perversions that often underlie criminality (Ressler & Schactman, 1992). The psychopath’s famous absence of conscience (Cleckley, 1941) evidences not only a defective superego (Johnson, 1949) but also a lack of primary attachments to other people. To the deeply antisocial person, the value of others reduces to their utility in allowing one to demonstrate clout.

Psychopathic people will brag outright about their con jobs, conquests, and scams if they think the listener can be thereby impressed with their power. There is nothing unconscious about this process; it is literally shameless. Law enforcement agents are repeatedly astounded at how readily criminals will confess to homicide yet will hide lesser offenses (sexual compulsions, taking a few dollars from a murder victim’s handbag), evidently because these are seen as signs of weakness (N. Susalis, personal communication, May 7, 1993). Kernberg (1984) refers to the psychopath’s “malignant grandiosity,” a phrase that rings true to anyone who has experienced such a person’s effort to triumph sadistically by sabotaging therapy.

It is important to distinguish between psychopathic manipulation and what is frequently

labeled manipulation in hysterical and borderline patients. The former is a deliberate, syntonically attempted use of others; the latter makes others *feel* used, while the patient may be relatively unaware of a specific manipulative intent. As I noted in [Chapter 4](#), I recommend restricting the term “manipulation” to the conscious, intentional psychopathic phenomenon. Hysterical and borderline patients may try to get their needs met by indirect means that exasperate others and provoke attributions of manipulation, but their behaviors have significantly different sources, and they are unconsciously intended to maintain relationships rather than to use others indifferently.

Early observers noted, and more recent research confirms (Robins, Tipp, & Przybeck, 1991), that many psychopathic people—those who have escaped self-destruction and incarceration—“burn out” in middle age, often becoming surprisingly upright citizens. They may become more amenable to psychotherapy then and may benefit from it more than younger people with psychopathic psychologies. This change may reflect hormonal decreases that reduce internal pressures toward action, but it also may reflect the loss of physical power that occurs at midlife. As long as omnipotent defenses are unthwarted by limits, a person’s motivation to develop more mature adaptations is minimal. Older adolescents and young adults of all personality types, especially healthy young men, typically have omnipotent feelings: death is far away, and the prerogatives of adulthood are at hand. Infantile grandiosity is reinforced. (I suspect that one reason psychopathy is more common in men is that females confront realistic limitation earlier: We are less physically strong; we live with the nuisance of menstruation and the danger of pregnancy; we are at greater risk of rape and physical abuse, and as primary caregivers, we are humbled by the discrepancy between our images of ideal maternal effectiveness and the emotional challenges of trying to rear civilized children.) But reality has a way of catching up with us, whatever our early advantages. By middle age, death is no longer an abstraction, physical strength has declined, reaction time is down, health cannot be taken for granted, and the long-term costs of hard living have begun to appear. These facts of life can have a maturing effect, interesting a person in less omnipotent adaptations.

As for projective identification, in psychopathic people a reliance on this process may reflect not only a developmental arrest and reliance on primitive defenses but also the consequences of their inarticulateness and emotional immaturity. Their inability and/or disinclination to express emotions verbally (except to manipulate) means that the only way they can get other people to understand what they are feeling is to evoke that feeling in them. The dissociative defenses of psychopaths are commonly noted but hard to evaluate in specific instances. Dissociative phenomena range from trivial instances of the minimizing of one’s role in some blunder to total amnesia for a violent crime. Disavowal of personal responsibility, which may have a dissociative quality, is a critical diagnostic indicator of psychopathy; the batterer who explains that he and his lover had a “tiff” and he “guesses he lost his temper” or the seemingly contrite cheater who claims to have “used bad judgment in this instance” is showing characteristic minimization. Interviewers who pick this up should ask for specifics: “What exactly did you do when you lost your temper?” or “What exactly did you judge wrong?” (usually the answer to the latter shows regret about getting caught, not

remorse about cheating).

When a psychopathic person claims to have been emotionally dissociated or amnesic during some experience, especially during the perpetration of an offense, it is hard to tell whether the experience was in fact dissociated or whether words to this effect are a manipulative evasion of responsibility. Given the frequency of severe abuse in the histories of people diagnosed as antisocial, and given the causal relationship between abuse and dissociation, it would be unimaginable for dissociation not to be a frequent concomitant of a psychopathic personality. Still, the unreliability of accounts by antisocial people makes the topic a vexing one. I say more about this in the differential diagnosis section at the end of this chapter and in [Chapter 15](#).

Acting out is virtually definitional of psychopathy. Not only do antisocial people have an internal goad toward action when aroused or upset, but they also have no experience of the increase in self-esteem that can come from control of impulse. Older clinical literature airs a controversy about whether psychopaths lack anxiety or whether their anxiety is invisible. Greenwald (1974) believed that they do feel anxious but that they act out so fast to relieve themselves of such a toxic feeling that the observer has no chance to see it (and they would never admit to anxiety if asked, as they would see it as “weak”). So far as we can investigate empirically, however, those who saw them as lacking anxiety were more accurate, at least with respect to true psychopaths: Their level of fear and upset tests way below that of nonpsychopathic people; they show no more reaction to a word like “rape” than to a word like “table” (Intrator et al., 1997), and they have virtually no startle response (Patrick, 1994). People with antisocial tendencies *who are healthy enough to participate in therapy* may have some anxiety, however (Gacano & Meloy, 1991; Gacano, Meloy, & Berg, 1992), and that anxiety may be a motivator that contributes to their capacity to benefit from treatment.

RELATIONAL PATTERNS IN PSYCHOPATHY

The childhoods of antisocial people are often rife with insecurity and chaos. Confusing amalgams of harsh discipline, overindulgence, and neglect have long been noted in the clinical literature (Abraham, 1935; Aichhorn, 1936; Akhtar, 1992; Bird, 2001; Greenacre, 1958; Redl & Wineman, 1951). Especially in the histories of violent psychopaths, one can find virtually no consistent, loving, protective influences. Weak, depressed, or masochistic mothers and explosive, inconsistent, or sadistic fathers have been linked with psychopathy, as have alcoholism and other addiction in the family. Moves, losses, and family break-ups are common. Under unstable and frightening circumstances like these, the normal confidence in one’s early omnipotent feelings and later in the power of others to protect the young self could not possibly develop normally. The absence of a sense of power at developmentally appropriate times may impel children in this predicament to spend the rest of their lives seeking confirmations of their omnipotence.

Even if they are aware of them, psychopathic people cannot acknowledge ordinary emotions

because they associate them with weakness and vulnerability. It is probable that in their families of origin, no one helped them put words to emotional experiences. They have no concept of using language to state feelings and no internalized basis for knowing another role for speech. Clinical observations suggest that in their families, words were used mostly to control others. The deficits of their caregivers in responding to their emotional needs are related to another piece of clinical lore: Children who become psychopathic have often been indulged materially and deprived emotionally. The parents of an antisocial patient of mine used to get her extravagant gifts (a stereo, a car) when she seemed upset. It did not occur to them to draw her out and listen to her concerns. This kind of “generosity” is particularly destructive; in the case of my patient, it left her no way to formulate her lingering sense that there was something missing in her life.

The most penetrating recent psychoanalytic thinking about psychopathy (e.g., Kernberg, 2004; Meloy, 1997) emphasizes the failure (from whatever accidents of temperament and rearing) of attachment and consequent internalization. The antisocial person seems never to have attached psychologically, incorporated good objects, or identified with caregivers. He or she did not take love in and never loved. Instead, identification may have been with a “stranger selfobject” (Grotstein, 1982) experienced as predatory. Meloy (1988) writes of “a paucity of deep and unconscious identifications with, initially, the primary parent figure and ultimately the archetypal and guiding identifications with the society and culture and humankind in general” (p. 44).

Many an adoptive parent has learned the hard way that children from destitute orphanages or other profoundly negligent/abusive backgrounds can have attachment disorders that render them permanently unable to love, no matter how devoted their later care. Young children with such histories often show disorganized–disoriented attachment, or the apparent absence of an internalized, organized attachment strategy (D. Diamond, 2004; Main & Solomon, 1986), in which the object of attachment may also be a source of terror and rage, producing contradictory behaviors such as smiling at the mother and biting her. One subtype of the disorganized–disoriented style is a disorganized–controlling style that shows up by age 6 in some maltreated children (Hesse & Main, 1999) that sounds consistent with long-time observations of psychopathic psychology.

An alternative origin of a character organized around omnipotent fantasies and antisocial behavior is a history in which parents or other important figures were deeply invested in the child’s omnipotence and sent repeated messages that life should pose no limits on the prerogatives of a person so inherently entitled to exert dominance. Such parents, identifying with the child’s defiance and acting out their own hatred of authority, tend to react with outrage when teachers, counselors, or lawenforcement agents try to set limits on their youngster. Like all character types, psychopathy can be “inherited” in that the child imitates the defensive solutions of the parents. When the main source of someone’s characterological psychopathy is parental modeling and reinforcement of manipulative and entitled behavior, the prognosis is probably better than when the condition is rooted in chaos and negligence. At least the child of indulgent, corrupting parents has succeeded in identifying with *someone* and has some capacity to connect. It may be that this kind of family

breeds healthier people with antisocial trends, and that more traumatic backgrounds breed more deeply disturbed individuals, including true or primary psychopaths.

THE PSYCHOPATHIC SELF

One biological substrate of a disposition toward psychopathy is a degree of aggression that would make a child difficult to calm, comfort, and mirror. Children who are innately hyperactive, demanding, distractible, and headstrong need much more active, energetic parenting than placid, easily consoled youngsters. They also arguably need much more direct involvement by a father figure than most preschoolers in Western societies get (Cath, 1986; M. J. Diamond, 2007; McWilliams, 2005a; J. Shapiro, Diamond, & Greenberg, 1995), and would probably benefit from additional caregivers as well. I have known highly aggressive children who were observably too much for one parent but who attached firmly if provided with enough stimulation and loving discipline. Given contemporary Western cultural assumptions that a single parent is adequate, we may be raising many more psychopaths in this part of the world than we would otherwise see.

Sociological conjectures aside, the condition of being viewed from day one as a problem child would make it very hard for a potential psychopath to find self-esteem via the normal route of feeling the caregivers' love and pride. When outside objects fail, the only object to invest in emotionally is the self and its personal power. Self-representations may be polarized between the desired condition of personal omnipotence and the feared condition of desperate weakness. Aggressive and sadistic acts may stabilize the sense of self in a psychopathic person by both reducing unpleasant states of arousal and restoring self-esteem.

David Berkowitz, the "Son of Sam" serial killer, began his murders of women after learning that his biological mother was something of a slattern rather than the elevated figure of his imagination (Abrahamsen, 1985). An adoptee, he had attached his self-esteem to the fantasy of having a superior "real" mother, and when this illusion was shattered, he went on a rampage. Similar connections between a crime spree and some blow to grandiosity have been noted in many sensational cases, but observation of manipulative people in ordinary life suggests that this pattern in its essentials is not limited to psychopathic killers. Anyone whose fondest images of self reflect unrealistic notions of superiority, and who runs into evidence that he or she is only human, may attempt to restore self-esteem by exerting power.

In addition, the more chaotic the environment of a child, and the more exhausted or inadequate the caregivers, the more likely it is that the youngster will not run into effective limits and will not have to take seriously the consequences of impulsive actions. From a social learning theory point of view, grandiosity in a child would be the expectable result of an upbringing that lacks consistent discipline. The condition of having much more energy than one's caregiver would teach the lesson that one can ignore the needs of others, do whatever feels compelling at the time, and handle any adverse consequences by escaping, dissimulating, and seducing or bullying others.

One other feature of self-experience in the psychopathic patient that deserves mention is primitive envy, the wish to destroy that which one most desires (Klein, 1957). Although antisocial people rarely articulate envy, many of their behaviors demonstrate it. One probably cannot grow up unable to love without knowing that there is something out there that other people enjoy that one lacks. Active devaluation and depreciation of anything in the tenderer realms of human life are characteristic of antisocial people at all levels of severity; those in the psychotic range have been known to kill what attracts them. The serial killer Ted Bundy, for example, described his need to destroy pretty young women (who, others noted, resembled his mother) as a kind of “owning” them (Michaud & Aynesworth, 1983). The killers portrayed in Truman Capote’s *In Cold Blood* (1965) exterminated a happy family “for no reason” except presumably that they were a happy family toward whom the exterminators could not bear to feel their consuming envy.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH PSYCHOPATHIC PATIENTS

The psychopathic person’s basic transference to a therapist is a projection of his or her internal predation, the assumption that the clinician intends to use the patient for selfish purposes. Not having had any emotional experience with love and empathy, the antisocial patient has no way to understand the generous aspects of the therapist’s interest and will try to figure out the practitioner’s “angle.” If the patient has reason to believe that the therapist can be used to promote some personal agenda (such as giving a good report to a judge or probation officer), he or she may be uncannily charming, so much so that an inexperienced clinician may be taken in.

The usual countertransference to the patient’s preoccupation with using the therapist or outsmarting the therapist’s presumably exploitive agenda is shock and resistance to the sense that one’s essential identity as a helper is being eradicated. The naive practitioner may succumb to the temptation to try to prove helpful intent. When that fails, hostility, contempt, and moralistic outrage toward the psychopathic person are common reactions. These “unempathic” feelings in ordinarily compassionate people should be understood, paradoxically, as a kind of empathy with psychopathic psychology: The client is unable to care about the therapist, and the therapist finds it almost as hard to care about the client. Outright hatred of the patient is not uncommon, and is no cause for worry, since the capacity to hate is a kind of attachment (Bollas, 1987). If one can tolerate the experience of internal coldness and even hatred, one will get an unpleasant but useful glimpse of what it is like to be a psychopathically organized person.

Other common countertransference reactions are complementary rather than concordant (Racker, 1968; see [Chapter 2](#)) and chiefly involve fear of a peculiarly ominous kind. People who work with psychopaths frequently comment on their cold, remorseless eyes and worry that such patients have them “under their thumb” (Meloy, 1988). Eerie forebodings are common. Again, it is

important that the clinician tolerate these upsetting reactions rather than try to deny or compensate for them, since minimizing the threat posed by a true sociopath is highly unwise (both realistically and because it may prompt the client to demonstrate his or her destructive power). Finally, the experience of being actively, even sadistically depreciated can provoke intense hostility or hopeless resignation in the clinician. Awareness that devaluing messages constitute a defense against envy is cold intellectual comfort in the face of a psychopath's unmitigated scorn, but it helps.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF PSYCHOPATHY

In light of the bad reputation of antisocial patients, I should say at the outset that I have known of many psychopathic people who were helped by psychotherapy. The therapist cannot be grandiose, however, about how much can be accomplished, and more than with individuals in other diagnostic categories, it is critical that a careful assessment be done to see whether or not any individual psychopathic patient is treatable. Some are so damaged, so dangerous, or so determined to destroy the therapist's aims that psychotherapy would be an exercise in futility and naiveté. Meloy (1988) makes a key distinction between the roles of evaluator and therapist, a discrimination that is unnecessary with patients of most other character types, since they lack the psychopath's aim of defeating the clinician. Meloy's explanation of the phenomenon of therapeutic nihilism (Lion, 1978) fits my own experience:

It is the stereotypical judgment that all psychopathically disturbed individuals, or antisocial personality disorders, *as a class*, are untreatable by virtue of their diagnosis. Such a judgment ignores both individual differences and the continuous nature of severity of psychopathology. I have most commonly observed this reaction in public mental health clinicians who are assigned patients on referral from probation, parole, or the court; and assume, because of the coercive nature of the treatment referral, that ... any psychotherapeutic gain is impossible.

Such reactions are often the product of attitudes that have been internalized as an "oral tradition" during training from senior, teaching clinicians. They are rarely the product of direct, individual experience. It is, in a sense, a mass retaliatory attitude where moral judgment impinges on professional assessment. The behavioral pathology of the psychopath, to devalue and dehumanize others, becomes the concordant identification of the clinician doing to the psychopath what the clinician perceives the psychopath doing to others. (Meloy, 1988, p. 325)

Karon and VandenBos (1981) made a comparable critique of the equally prevalent, empirically

unsupported belief that schizophrenia is not treatable; psychopathic patients at a psychotic level of personality organization thus may have two strikes against them.

Attitudes about the inherent untreatability of all psychopathic individuals may also reflect the fact that in most training programs—even those that send their students into internship and practicum placements at jails, youth correctional facilities, and drug treatment centers that contain many psychopathic people—very little if any attention is paid to the development of the skills appropriate for this group. When new therapists fail using approaches that are effective with other populations, they may blame the patient rather than the limitations of their training.

The assessment of treatability is beyond the scope of this text, but I recommend using Kernberg's structural interview (B. L. Stern et al., 2004) to evaluate whether psychotherapy should be undertaken with any particular psychopathic person. DSM-IV is not useful here. Its criteria for antisocial personality disorder were normed on prison inmates and developed with researchers rather than therapists in mind. With the exception of lack of remorse, DSM-IV criteria for assessing antisocial personality disorder are all factors that can be observed externally by the clinically untrained; they do not necessarily pick up critical internal, subjective states. Hence, they tend to overdiagnose people with backgrounds of poverty, oppression, and marginality (who may run afoul of authorities for many reasons other than their individual psychology) and to underdiagnose successful, socially prominent psychopaths. As I write this, it appears that in DSM-5, antisocial psychology will be reframed as on the narcissistic spectrum and may be defined more internally.

Once one has decided to work with a psychopathic person—or has realized that a current patient is significantly antisocial—the most critical feature of treatment is incorruptibility: of the therapist, the frame, and the conditions that make therapy possible. It is much better to err on the side of inflexibility than to show, in the hope that it will be seen as empathy, what the client will see as weakness. Psychopathic people do not understand empathy. They understand using people, and they will feel a sadistic triumph over, not a grateful appreciation for, a therapist who wavers from the boundaries of the treatment contract. Any behavior that can be interpreted as weakness and vulnerability probably will be. Anthony Hopkins gave a chilling portrayal of the psychopath's talent for finding someone's Achilles' heel in his character's manipulation of the detective played by Jodie Foster in *The Silence of the Lambs*. The writers of the television series *Dexter* have clearly done their homework; like the authors of *The Sopranos*, they have managed a plot device that allows the viewer to care about a lead character who has extreme *but not total* psychopathy. Dexter is capable of some attachment, but the portrayal of his internal world through his voiceover comments shows a lot about the emotional limitations of the significantly antisocial person.

It is unrealistic to expect love from antisocial people, but one can earn their respect by coming across as tough-minded and exacting. When I work with psychopathic patients, I insist on payment at the beginning of each session and send the client away in its absence—no matter how reasonable the explanation offered. Like most therapists who were taught to bend over backward to consider the special needs of each client, I had to learn from experience that not bending at all is the right

response to the needs of the antisocial patient. Early in therapy I do not analyze such patients' assumed motives for testing the solidity of the contract, I merely remind them that our deal was that they would pay up front, and I repeat that I will hold up my end of the deal—the application of my expertise to help them understand themselves better—if they hold up theirs.

Related to incorruptibility is uncompromising honesty: talking straight, keeping promises, making good on threats, and persistently addressing reality. Honesty includes the therapist's private admission of intense negative feelings toward the patient, both countertransferences and realistic perceptions of danger. If such reactions are denied, countertransferences may be acted out and legitimate fears may be minimized. To treat psychopathic clients we must make peace with our own antisocial tendencies so that we have a basis for identifying with the patient's psychology. With respect to money discussions, for example, we should nondefensively admit selfishness and greed when giving a rationale for the fee. Some therapists cannot work with psychopathic people, as they cannot find in themselves enough antisocial features to permit any sense of commonality.

Except for admissions like the above that legitimately pertain to the therapeutic contract, honesty does not mean disclosure; self-revelation will only be interpreted as frailty. Nor does it mean moralizing. When considering the patient's destructive actions, it is futile to invite the expression of assumed feelings of badness or guilt. The patient lacks a normal superego and probably committed the sins in order to feel good (omnipotent) rather than bad (weak). One must restrict oneself to addressing the possible realistic outcomes of amoral behavior. Probes into presumed struggles with conscience tend to evoke responses like the one attributed to Willie Sutton when he was asked why he robbed banks: "Because that's where the money is."

The therapist's unrelenting emphasis on the realistic risks of each grandiose design need not be humorless just because the matters at hand have serious consequences. One of my colleagues, a woman renowned for her talent with antisocial clients, reports the following banter with a court-remanded car thief:

"The man was explaining to me how brilliant his scheme had been for the heist he had almost pulled off, how if only one little unforeseen thing hadn't happened, it would have been the perfect crime. As he talked, he was getting more and more excited and animated, and I agreed with some admiration that he had almost gotten away with the theft. It started to feel like we were co-conspirators. Eventually, he got so carried away that he asked, 'Would you do something like that?'

" 'No,' I answered.

" 'Why not?' he asked, a little deflated.

" 'Two reasons,' I said. 'First, there's always some little thing that can go wrong, even with a brilliant plan. Life isn't that controllable. And then I'd be in jail, or in a mental hospital involuntarily, like you are, talking to some shrink I didn't choose myself. And second, I wouldn't because I have something that you don't: a conscience.'

“ ‘Yeah,’ he said. ‘You know how I could get one of those?’ ”

Of course, the first step in developing a conscience is to care about someone to the degree that that person’s opinion matters. Without moralizing, the therapist moves the patient along toward more responsible behavior simply by being a consistent, nonpunitive, nonexploitable object. Harold Greenwald (1958, 1974), who worked with antisocial people in the Los Angeles underworld, described how he would connect with psychopaths in terms that they could understand. He reasoned that since power is the only quality antisocial people respect, power is the first thing the therapist must demonstrate. He gives the following instance of claiming his own power:

A pimp came to see me and started to discuss his way of life. He said, “You know I’m ashamed to show myself and so on, but after all, it’s a pretty good way to live and most guys would want to live that way, you know, to live as a pimp. It’s not bad—you get girls out hustling for you—why shouldn’t you do it? Why shouldn’t anybody do it?” I said, “You’re a jerk.” He asked why. I replied, “Look, I live off the earnings of call girls. I wrote a book about them; I got respect for it; I got famous from it; they made a movie out of it. I made much more money off call girls than you ever will, and you, you schmuck, you can get arrested any day and be sent to jail for ten years, whereas I get respect, honor, and admiration.” This he could understand. He saw that somebody whom he considered similar to him had a superior way of accomplishing the same ends. (1974, p. 371)

Greenwald has his own free-wheeling but still essentially incorruptible style with psychopathic patients. He is not the only therapist who has discovered the utility of “outpsyching the psychopath” or “conning the con” as a way of demonstrating that he deserves respect. Like my colleague previously quoted, he can own enough psychopathic impulses in himself that he does not feel fully alienated from the emotional world of his clients. Tellingly, he reports that in the second or third year of intensive treatment with him, psychopathic patients often go into a serious, even psychotic depression. He sees this as evidence that they have started to care about him in a genuine way rather than as an object to manipulate and, realizing this, they descend into a state of misery about their dependency. This depression, which only slowly lifts, compares in its essentials to Klein’s (1935) description of the feelings of infants in the second 6 months of life, when the child makes the painful discovery that the mother exists as a separate person outside the baby’s control.

In contrast with appropriate therapy with people of other diagnoses, the therapist of a psychopathic client may have to adopt an attitude of independent strength verging on indifference. I assume this applies to cognitive-behavioral therapies, some of which have shown promise with this population (M. H. Stone, 2000), as well as to analytically informed ones. One cannot seem emotionally invested in the patient’s changing, because as soon as an antisocial person sees that need, he or she can sabotage psychotherapy to demonstrate the clinician’s impotence. It is better to invest in simply increasing one’s understanding, setting the tone that one will do one’s job competently, and to communicate that it is up to the patient to take advantage of therapy or not. This principle is analogous to the lesson every police officer learns about investigating a crime:

Never show the suspect that it is important to you to get a confession.

The most skilled interviewer of antisocial people I know was for a long time the chief of detectives in my town, a man with an exceptional record of evoking confessions—often movingly tearful ones—from rapists, child torturers, murderers, and serial killers. Listening to tapes of his interrogations, one is struck by his attitude of respect and his quiet conviction that even the most monstrous perpetrator has a need to tell someone the truth. The suspects' responsiveness to being treated with dignity is poignant—the more so in light of their knowledge that the interviewer's agenda is to prosecute. No one interrogated by him has ever complained of betrayal, even as he testifies against them in court on the basis of their confession. "He treated me fair," they report.

These phenomena raise the question of whether the fabled callousness of the psychopath is a response to environments that are either abusive (as was childhood, later replicated by a savage subculture) or incomprehensible (as is a therapist's wish to help). The fact that these perpetrators are palpably relieved to confess to someone who wants to incarcerate them suggests that even an incorrigible felon may have a primitive sense of accountability and can gain something from a relationship. The sadistic murderer Carl Panzram (Gaddis & Long, 1970) had a lifelong friendship with a prison guard who once showed him ordinary kindness. Rigorous tough-mindedness and rock-bottom respect seem to be a winning combination with antisocial people. (This observation does not equate to an argument for "leniency" toward dangerous criminals. Understanding that psychopathic people are human beings who may be helped to some degree should not be confused with wishful thinking that therapy can transform a compulsive killer into a model of citizenship. The public needs protection from antisocial people whether or not their crimes are comprehensible psychodynamically and whether or not they can profit from a therapeutic relationship.)

The overall aim of work with a psychopathic individual is to help the patient move toward Klein's depressive position, in which others are seen as separate subjects worthy of concern (Kernberg, 1992). Over the course of treatment, as the psychopathic person's omnipotent control, projective identification, domination by envy, and self-destructive activities are dispassionately examined in an atmosphere of consistency and respect, the patient will in fact change. Any shift from using words to manipulate to using them for honest self-expression is a substantial achievement, one that may occur simply through the antisocial person's repeated exposure to someone with integrity. Any instance where the client inhibits an impulse and learns something about pride in self-control should be seen as a milestone. Since even a small movement toward human relatedness in a psychopath may prevent an immense amount of human suffering, such progress is worth every drop of sweat the practitioner secretes in its service.

DIFFERENTIAL DIAGNOSIS

It is not usually hard to spot the antisocial features in any client whose personality has a psychopathic component. Whether those features are central enough to define the person as

characterologically psychopathic is a more subtle question. Psychologies that can easily be misunderstood as essentially antisocial include paranoid, dissociative, and narcissistic conditions. The behavior of addicted individuals often mimics psychopathy. In addition, some people with hysterical personalities become misdiagnosed as psychopathic, a topic I discuss in [Chapter 14](#).

Psychopathic versus Paranoid Personality

There is considerable overlap between predominantly psychopathic psychologies and those that are more paranoid; many people have a lot of each sensibility. Both antisocial and paranoid people are highly concerned with issues of power, but from different perspectives. Unlike psychopaths, people with essentially paranoid character structure have profound guilt, the analysis of which is critical to their recovery from suffering. Thus, it is vital to assess with anyone who has both paranoid and psychopathic features which tendencies predominate.

Psychopathic versus Dissociative Personality

There is also considerable overlap between psychopathic and dissociative conditions. It is critical for an interviewer to evaluate whether a patient is a basically psychopathic person who uses some dissociative defenses or whether he or she has a dissociative psychology with one or more antisocial or persecutory alter personalities. The prognosis for the former kind of patient is guarded, whereas many essentially dissociative people, when accurately diagnosed, respond favorably to therapy. Unfortunately, this evaluation can be exceedingly difficult, even when done by an expert. Both primarily dissociative and primarily psychopathic people have a deep distrust of others, and for different reasons (terror of abuse vs. omnipotent triumph), both may dissimulate, comply superficially, and subvert the therapist.

I do not recommend trying to make this differential diagnosis when some important consequence hinges on it—for instance, when a man who has committed homicide may plead not guilty by reason of insanity if he can convince a professional that he has dissociative identity disorder. The differential diagnosis is hard enough without that complication, although regrettably, it is such a pivotal legal distinction that evaluators are working to develop procedures to make it more reliable. Even trained forensic psychologists have a tough time with these calls. I say more on this differential in [Chapter 15](#).

Psychopathic versus Narcissistic Personality

Finally, there is a close connection between psychopathic and narcissistic conditions: there is a continuum from minor narcissism through malignant narcissism to outright psychopathy. Both predominantly narcissistic and predominantly psychopathic people have a subjectively empty internal world and a dependence on external events to provide self-esteem. The dimensional formulation, originally suggested by Kernberg (1984), has always made sense to me and now has

enough recent research support that, as of the time I write, the authors of DSM-5 are planning to put these disorders of self on one spectrum. But I would also suggest that antisocial and narcissistic people are different enough to warrant thinking in terms of a continuum for each.

Most psychopathic individuals do not idealize repetitively, and most narcissistic ones do not depend on omnipotent control. Many people have aspects of both character types, and self-inflation can characterize either one, but prognosis improves in inverse relation to the psychopathic pole. Because treatment considerations are quite different for the two groups (e.g., sympathetic mirroring comforts most narcissistic people but antagonizes antisocial ones), despite the things they have in common and the number of people who have aspects of each orientation, it seems to me clinically useful to differentiate carefully between them.

Psychopathic Personality versus Addiction

People struggling with substance use disorders are notoriously manipulative and exploitive, as the addictive substance becomes more important to them than human relationships or personal integrity. Because of their antisocial *behavior*, observers commonly infer that their personalities are psychopathic. Although some addicted people may be characterologically antisocial, the personality organization of substance abusers cannot be inferred reliably until the interviewer has obtained reliable information about their behavior prior to their addiction or until they have been in recovery for a considerable length of time and their basic personality has emerged.

SUMMARY

In this chapter I portrayed the psychopathic personality as expressing an organizing need to feel one's effect on other people, to manipulate them, to "get over on" them. I summarized some constitutional predispositions to antisocial behaviors and mentioned the rage and mania that may briefly interrupt the affect block characteristic of antisocial persons. I discussed psychopathy in terms of the defenses of omnipotent control, projective identification, dissociation, and acting out; of object relations marked by instability, pandering, emotional misunderstanding, exploitation, and sometimes brutality; and a self-structure dominated by grandiose efforts to avoid a sense of weakness and envy. I mentioned putatively unempathic transference and countertransference reactions and stressed the importance of the therapist's incorruptibility, consistency, and self-conscious renunciation of the need to be seen as helpful. I differentiated psychopathic character from paranoid, dissociative, and narcissistic psychologies, and from the consequences of addiction.

SUGGESTIONS FOR FURTHER READING

Unfortunately, texts on psychotherapy as a general process rarely give psychopathic clients much

attention, and there is a relative paucity of good analytic literature on this group. For an excellent collection of seminal psychoanalytic articles on psychopathy, I recommend Meloy's edited collection, *The Mark of Cain* (2001). Bursten's study *The Manipulator* (1973a) and Meloy's *The Psychopathic Mind* (1988) are comprehensive and readable explorations with some attention to therapy issues. Akhtar also has a good chapter on the topic in *Broken Structures* (1992). Hare's *Without Conscience* (1999) is excellent, and his account with Babiak of *Snakes in Suits* (2007) is compelling.

Narcissistic Personalities

The term “narcissistic” refers to people whose personalities are organized around maintaining their self-esteem by getting affirmation from outside themselves. All of us have vulnerabilities in our sense of who we are and how valuable we feel, and we try to run our lives so that we can feel good about ourselves. Our pride is enhanced by approval and injured by disapproval from significant others. In some of us, concerns with “narcissistic supplies,” or supports to self-esteem, eclipse other issues to such an extent that we may be considered excessively self-preoccupied. Terms like “narcissistic personality” and “pathological narcissism” apply to this disproportionate degree of self-concern, not to ordinary responsiveness to approval and sensitivity to criticism.

Narcissism, normal as well as pathological, is a topic to which Freud (1914a) gave recurrent attention. He borrowed the term from the Greek myth of Narcissus, the youth who fell in love with his reflection in a pool of water and eventually died of a kind of longing that his image could never satisfy. Yet Freud had little to say about therapy for those in whom narcissistic concerns are central. Alfred Adler (e.g., 1927) and Otto Rank (e.g., 1929) both wrote on topics we would now include under narcissism, but their respective estrangements from Freud made their work unfamiliar to many therapists. Since the early psychoanalytic era, it has been noted that some people have problems with self-esteem that are hard to construe solely in terms of drives and unconscious conflicts, and are correspondingly hard to treat by reference to conflict-based models of therapy. A deficit model seems to fit their experience better: There is something missing from their inner lives.

Preoccupied with how they appear to others, narcissistically organized people may privately feel fraudulent and loveless. Ways of helping them to develop self-acceptance and to deepen their relationships awaited the expansion of dynamic psychology into areas that Freud had only begun to touch. Attention to concepts like basic security and identity (Erikson, 1950, 1968; Sullivan, 1953); the self as opposed to the more functionalist concept of the ego (Jacobson, 1964; Winnicott, 1960b); self-esteem regulation (A. Reich, 1960); attachment and separation (Bowlby, 1969, 1973; Spitz, 1965); developmental arrest and deficit (Kohut, 1971; Stolorow & Lachmann, 1978); shame (H. B. Lewis, 1971; Lynd, 1958; Morrison, 1989); and affect regulation, trauma, and attachment (Banai, Mikulincer, & Shaver, 2005; Schore, 2002) contributed to our understanding of narcissism.

As new theoretical areas were explored in the post-Freudian years, old areas were reworked,

leading to improvements in treating narcissistic problems. Much ferment followed challenges by object relations theorists (Balint, 1960; Fairbairn, 1954; Horney, 1939) to Freud's concept of "primary narcissism," the assumption that the infant cathects (invests emotionally in) self before others. Thinkers who stressed primary *relatedness* understood narcissistic pathology not as fixation on normal infantile grandiosity but as compensatory for early disappointments in relationship. Around the same time, notions like containment (Bion, 1967), the holding environment (Modell, 1976; Winnicott, 1960b), and mirroring (Kohut, 1968; Winnicott, 1967) were redefining theories of therapy. These ideas were more applicable than earlier models of psychopathology and treatment to people for whom the continuity of a sense of self, and the feelings of reasonable worth attached to it, are fundamentally problematic.

It is also likely that when Freud was writing, narcissistic problems of the kind that are epidemic today were less common. Psychoanalytically influenced social theorists (e.g., Cushman, 1995; Fromm, 1947; Hendin, 1975; Lasch, 1978, 1984; Layton, 2004; Slater, 1970) have argued that the vicissitudes of contemporary life reinforce narcissistic concerns. The world changes rapidly; we move frequently; mass communications exploit our insecurities and pander to our vanity and greed; secularization dilutes the internal norms that religious traditions once provided. In mass societies and in times of rapid change, the immediate impression one makes may be more compelling than one's integrity and sincerity, qualities that are prized in smaller, more stable communities where people know each other well enough to make judgments based on someone's history and reputation. In the United States, a climate of narcissistic absorption may not be a particularly recent phenomenon. In 1831, Alexis de Tocqueville (2002) noted that a society that touts equality of opportunity leaves citizens concerned with how to demonstrate their claim to special worth. Without a class system to provide visible levels of status, they try to accumulate observable evidence of their superiority, as inferiority would be equated with personal failure.

Many of Freud's patients suffered from too much internal commentary about their goodness or badness, a condition he came to depict as reflecting a "harsh superego." Contemporary clients, in contrast, often feel subjectively empty rather than full of critical internalizations; they worry that they "don't fit in" rather than that they are betraying their principles, and they may ruminate about observable assets such as beauty, fame, wealth, or the appearance of political correctness rather than more private aspects of their identity and integrity. Image replaces substance, and what Jung (1945) called the persona (the self one shows to the world) becomes more vivid and dependable than one's actual person.

Ernest Jones (1913) may have been the first analytic writer to describe the more overtly grandiose narcissistic person. He depicted a man characterized by exhibitionism, aloofness, emotional inaccessibility, fantasies of omnipotence, overvaluation of his creativity, and a tendency to be judgmental. He portrayed such individuals as on a continuum from psychotic to normal, commenting that "when such men become insane they are apt to express openly the delusion that they actually are God, and instances of the kind are to be met within every asylum" (p. 245). W.

Reich (1933) devoted a section of *Character Analysis* to the “phallic–narcissistic character,” represented as “self-assured ... arrogant ... energetic, often impressive in his bearing ... [who] will usually anticipate any impending attack with an attack of his own” (pp. 217–218). This familiar type appears in its essentials in the DSM-IV criteria for narcissistic personality disorder.

As psychoanalytic observations of personality continued, it became clear that the overtly grandiose personality was only one form of a “disorder of the self” (Kohut & Wolf, 1978). Current analytic conceptualization recognizes many different external manifestations of a core difficulty with identity and self-esteem. Bursten (1973b) suggested a typology of narcissistic personalities that includes craving, paranoid, manipulative, and phallic narcissistic subvarieties. Many have noted that in every vain, grandiose narcissist hides a self-conscious, shame-faced child, and in every depressed and self-critical narcissist lurks a grandiose vision of what that person should or could be (Meissner, 1979; A. Miller, 1975; Morrison, 1983). Repeatedly, the clinical literature has distinguished between two versions of narcissism, variously dubbed the “oblivious” versus the “hypervigilant” type (Gabbard, 1989), the overt versus the covert or “shy” type (Akhtar, 2000); the exhibitionistic versus the “closet” type (Masterson, 1993), and (my personal favorite) the “thick-skinned” versus the “thin-skinned” type (Rosenfeld, 1987). Pharis (2004) has described a “virtuous narcissist,” often an inspiring political figure, who accomplishes great things but quietly lets an associate take blame for any mistakes.

What narcissistic people of all appearances have in common is an inner sense of, and/or terror of, insufficiency, shame, weakness, and inferiority (Cooper, 1984). Their compensatory behaviors might diverge greatly yet still reveal similar preoccupations. Hence, individuals as different as Janis Joplin and Socrates’s problematic student Alcibiades might be reasonably viewed as narcissistically organized.

DRIVE, AFFECT, AND TEMPERAMENT IN NARCISSISM

I am not aware of research on the topic of constitutional and temperamental contributions to narcissistic personality organization in adulthood. Unlike antisocial people, who pose obvious and costly problems to society and therefore prompt funding for scientific investigation into psychopathy, narcissistic individuals are quite diverse, often subtle in their pathology, and not so patently damaging. Successful narcissistic people (monetarily, socially, politically, militarily, or however their success is manifested) may be admired and emulated. The internal costs of narcissistic hunger for recognition are rarely visible to onlookers, and injuries done to others in the pursuit of narcissistically driven projects may be rationalized as trivial or necessary side effects of competence (“You can’t make an omelet without breaking eggs”). Also, recognition of more subtle kinds of narcissism as treatable character problems is an achievement of only the past few decades.

Although Shedler and Westen’s work (e.g., 2010) establishes that therapists are quite reliable in identifying narcissistic dynamics, most of our ideas about etiology are still untested, clinically

generated hypotheses. One of these is that people at risk for developing a narcissistic character structure may be constitutionally more sensitive than others to un verbalized emotional messages. Specifically, narcissism has been associated with the kind of infant who seems preternaturally attuned to the unstated affects, attitudes, and expectations of others. Alice Miller (1975) suggested, for example, that many families contain one child whose natural intuitive talents are unconsciously exploited by his or her caregivers for the maintenance of their self-esteem and that this child grows up confused about whose life he or she is supposed to lead. Miller believed that such gifted children are more likely than untalented youngsters to be treated as “narcissistic extensions” of their caregivers and are hence more apt to become narcissistic adults.

On a different note, in discussing entitled, grandiose narcissistic clients, Kernberg (1970) has suggested that they may have either an innately strong aggressive drive or a constitutionally determined lack of tolerance for anxiety about aggressive impulses. Such dispositions would partially explain the lengths to which narcissistic people may go to avoid acknowledging their own drives and appetites: They may be scared of their power. Beyond these speculations, we know little about temperamental propensities that may contribute to a narcissistic character structure.

As for the main emotions associated with narcissistic personality organization, shame and envy are recurrently stressed in the clinical literature (e.g., Steiner, 2006). Feelings of shame and fears of being shamed pervade the subjective experience of narcissistic people. The early analysts underestimated the power of this emotional state, often mistaking it for guilt and making guilt-oriented interpretations that narcissistic patients found unempathic. Guilt is the conviction that one is sinful or has committed wrongdoings; it is easily conceptualized in terms of an internal critical parent or the superego. Shame is the sense of being *seen* as bad or wrong; the audience here is outside the self. Guilt carries with it a sense of an active potential for evil, whereas shame has connotations of helplessness, ugliness, and impotence.

The narcissistic person’s vulnerability to envy is a related phenomenon, one that Melanie Klein’s work illuminates (Segal, 1997). If I have an internal conviction that I am lacking in some way and that my inadequacies are at constant risk of exposure, I will be envious toward those who seem content or who have assets that I believe would make up for what I lack. Envy may also be the root of the much-noted judgmental quality of narcissistically organized persons, toward themselves and toward others. If I feel deficient and I perceive you as having it all, I may try to destroy what you have by deploring, scorning, or ridiculing it.

DEFENSIVE AND ADAPTIVE PROCESSES IN NARCISSISM

Narcissistically structured people may use a whole range of defenses, but the ones they depend on most fundamentally are idealization and devaluation. These processes are complementary, in that when the self is idealized, others are devalued, and vice versa. Kohut (1971) originally used the term “grandiose self” to capture the sense of self-aggrandizement and superiority that characterizes

one polarity of the inner world of narcissistic people. This grandiosity may be felt internally, or it may be projected. There is a constant “ranking” process that narcissistic people use to address any issue that faces them: Who is the “best” doctor? What is the “finest” preschool? Where is the “most rigorous” training? Realistic advantages and disadvantages may be completely overridden by concerns about comparative prestige.

For example, a woman I know was determined that her son would go to the “best” college. She took him to see several exclusive schools, pulled strings where she had any, and even wrote thank-you notes to deans of admission with whom he had interviewed. By mid-April, he had been accepted by several excellent colleges and universities, and he was on the waiting list at Yale. Her response was a sense of devastation that he had been rejected by Harvard. The young man elected to attend Princeton. Throughout his freshman year, his mother badgered Harvard to take him as a transfer student. Although he thrived at Princeton, when Harvard finally capitulated to his mother’s relentless entreaties, there was no question about his destination.

The subordination of other concerns to issues of general valuation and devaluation is of note here. This mother knew that professors in her son’s chosen field considered Harvard inferior to Princeton in that area; she also knew that Harvard undergraduates tend to receive less attention than those at Princeton; and she was aware that her son would suffer socially at Harvard for missing his freshman year there. Nevertheless, she persisted. Although she did not have a diagnosable narcissistic personality disorder, this woman used her son as a narcissistic extension in this instance because she had a defensive belief system that included the conviction that her own life would have been dramatically transformed had she gone to Radcliffe, the “sister” school to Harvard and the “best” school for women at the time she was applying to college.

In an instance where a parent’s valuation and devaluation were characterological, a patient of mine, a college student with artistic and literary sensibilities, was told by his grandiose father that he would support his becoming a doctor (preferably) or a lawyer (if he proved untalented in the natural sciences), but nothing else. Medicine and law would bring in money and command respect; any other career would reflect badly on the family. Because this young man had been treated like a narcissistic extension his whole life, he saw nothing unusual in his father’s position, which is culturally quite aberrant in the United States.

A related defensive position in which narcissistically motivated people are trapped concerns perfectionism. They hold themselves up to unrealistic ideals and either convince themselves that they have attained them (the grandiose outcome) or respond to their falling short by feeling inherently flawed rather than forgivably human (the depressive outcome). In therapy, they may have the ego-syntonic expectation that the point of undergoing treatment is to perfect the self rather than to understand it and to find more effective ways of handling its needs. The demand for perfection is expressed in chronic criticism of self or others (depending on whether or not the devalued self is projected) and in an inability to find joy amid the ambiguities of human existence.

Sometimes narcissistic people handle their self-esteem problem by regarding someone else—a

lover, a mentor, a hero—as perfect and then feeling inflated by identification with that person (“I am an appendage of So-and-so, who can do no wrong”). Some have lifelong patterns of idealizing someone and then sweeping that idol off the pedestal when an imperfection appears. Perfectionistic solutions to narcissistic dilemmas are inherently self-defeating: One creates exaggerated ideals to compensate for defects in the sense of self that are felt as so contemptible that nothing short of perfection will make up for them, and yet, since no one is perfect, the strategy is doomed, and the depreciated self emerges again.

RELATIONAL PATTERNS IN NARCISSISM

From this description of some of their dynamics, the reader has probably already concluded that relationships between narcissistic people and others are overly burdened with the self-esteem issues of the narcissistic party. Although it is rare for someone with a narcissistic personality disorder to come to therapy with the explicit agenda of becoming a better friend or family member or lover, it is not uncommon for clients with this problem, especially in midlife or later, to be aware that something is wrong in their interactions with others. One problem in helping them is conveying to them what it would be like to accept a person nonjudgmentally and nonexploitively, to love others as they are, without idealizing, and to express genuine feelings without shame. Narcissistic people may have no concept of such possibilities; the therapist’s acceptance of them can become the prototype for their emotional understanding of intimacy.

Self psychologists have coined the term “selfobjects” for the people in our lives who support our self-esteem by their affirmation, admiration, and approval (see Basch, 1994). The term reflects the fact that individuals in that role function as objects outside the self and also as part of one’s self-definition. By helping to modulate self-esteem, they augment what most of us also do internally. We all have selfobjects, and we need them. If we lose them we feel diminished, as if some vital piece of us has died. Yet reality and morality require that others be more than selfobjects, that we *recognize* them (Benjamin, 1988) in terms of who they are and what they need, not just in terms of what they do for us.

The narcissistic person needs selfobjects so greatly that other aspects of relationship pale, and may even be unimaginable, as they were to my client whose father would not support his being anything but a doctor or lawyer. Thus, the most grievous cost of a narcissistic orientation is a stunted capacity to love. Despite the importance of other people to the equilibrium of a narcissistic person, his or her consuming need for reassurance about self-worth leaves no energy for others except in their function as selfobjects and narcissistic extensions. Hence, narcissistic people send confusing messages to their friends and families: Their need for others is deep, but their love for them is shallow. Symington (1993) believes that the ultimate cause of this deficit is a child’s having repudiated, for whatever reason, the original emotional “lifegiver,” with the long-term consequence of internal deadness and incapacity to find one’s vitality.

Some theorize that people get this way by having been used as narcissistic appendages themselves. Narcissistic clients may have been vitally important to parents or other caregivers, not because of who they really were but because of the function they fulfilled. The confusing message that one is highly valued, but only for a particular role that one plays, makes children worry that if their real feelings, especially hostile or selfish ones, are visible, rejection or humiliation will follow. It fosters the development of what Winnicott (1960a) called the “false self,” the presentation of what one has learned is acceptable. A crucial difference between the etiologies of psychopathy and narcissism may be that whereas antisocial psychology derives from overt abuse and neglect, narcissistic psychology springs from a particular kind of attention or even doting, in which support is given on the implicit condition that the child cooperate with a parent’s narcissistic agenda.

I assume that most parents regard their children with a combination of narcissistic needs and true empathy. In moderation, children enjoy being treated as narcissistic extensions. Making parents feel proud, as if they also have been admired when their son or daughter gets recognition, is one of the sweeter pleasures of childhood. As usual, the issue is one of degree and balance: Does the child also get attention unrelated to whether the parent’s aims are furthered? A markedly non-narcissistic attitude toward offspring informs the remarks of a now-deceased friend of mine who reared 12 children during the 1930s, all of whom have turned out well despite borderline poverty and some painful losses:

“Every time I’d get pregnant, I’d cry. I’d wonder where the money would come from, how I was going to nurse this child and take care of everything else. But around the fourth month I’d begin to feel life, and I’d get all excited, thinking, ‘I can’t wait till you come out and I find out who you are!’”

I quote this to contrast her sentiments with those of a prospective parent who “knows” who the child is going to be: Someone to be molded by the parent into a person who realizes all the parent’s failed ambitions and brings reflected glory to the family.

A related aspect of the upbringing of people who become narcissistic is a family atmosphere of constant evaluation. If I have an agenda for a child that is vital to my own self-esteem, then every time that child disappoints me, I will be implicitly or explicitly critical. I doubt that anyone has ever brought up a child without criticism, but the background message that one is not good enough in some vague way is quite different from specific feedback on behaviors that offend. An evaluative atmosphere of perpetual praise and applause, which one finds in some families with narcissistic children, is equally damaging to the development of realistic self-esteem. The child is always aware of being judged, even if the verdict is positive. He or she knows on some level that there is a false quality to the attitude of constant admiration, and despite the conscious sense of entitlement that may issue from such a background, it creates a nagging worry that one is a bit of a fraud, undeserving of this adulation that seems tangential to who one really is. Fernando (1998) has argued that overindulgence of this kind is the primary etiology of pathological narcissism. Fiscalini

(1993), noting different versions of narcissistic orientation, identified the shamed child, the spoiled child, and the special child as precursors of pathological narcissism in adulthood.

Thus we see again how certain character structures can be “inherited,” though parents do not have to have narcissistic personalities themselves to rear a son or daughter who is disturbed narcissistically. Parents may have narcissistic needs toward a particular child (as in the case of the woman whose son had to go to Harvard) that set the stage for that child’s not being able to discriminate between genuine feelings and efforts to please or impress others. What is a nonissue to one parent is a central one to another. We all want for our children the things we lacked, a harmless desire as long as we spare them any pressure to live their lives for our sakes.

Martha Wolfenstein gave us an interesting glimpse of narcissistic processes in a 1951 article “The Emergence of Fun Morality,” depicting how liberal intellectual New Yorkers in the postwar era, having grown up during hard times, gave their children the message that they should feel bad about themselves if they were not *having fun*. People whose options were drastically curtailed by some disaster such as war or persecution are apt to send signals that their children should live the life they never had. Frequently, the children of traumatized parents grow up with some identity confusion and feelings of vague shame and emptiness (see Bergmann, 1985; Fogelman, 1988; Fogelman & Savran, 1979). The communication that “unlike me, you can have it all” is particularly destructive, in that no one can have it all; every generation will face its own constraints. For self-esteem to be contingent on such an unrealistic goal is a crippling inheritance.

THE NARCISSISTIC SELF

I have already alluded to many of the self-experiences of people who are diagnosably narcissistic. They include a sense of vague falseness, shame, envy, emptiness or incompleteness, ugliness, and inferiority, or their compensatory counterparts: self-righteousness, pride, contempt, defensive self-sufficiency, vanity, and superiority. Kernberg (1975) describes such polarities as opposite ego states, grandiose (all-good) versus depleted (all-bad) definitions of self, which are the only options narcissistic persons have for organizing their inner experience. The sense of being “good enough” is not one of their internal categories.

Narcissistically structured people are aware at some level of their psychological fragility. They are afraid of falling apart, of precipitously losing their self-esteem or self-coherence (e.g., when criticized), and abruptly feeling like nobody rather than somebody (Goldberg, 1990b). They sense that their identity is too tenuous to hold together and weather some strain. Their fear of the fragmentation of their inner self is often displaced into a preoccupation with their physical health; thus, they are vulnerable to hypochondriacal preoccupations and morbid fears of death.

One subtle outcome of the perfectionism of narcissistic people is the avoidance of feelings and actions that express awareness of either personal fallibility or realistic dependence on others. In particular, remorse and gratitude are attitudes that narcissistic people tend to deny (McWilliams &

Lependorf, 1990). Remorse about some personal error or injury includes an admission of defect, and gratitude for someone's help acknowledges one's need. Because narcissistic individuals try to build a sense of self on the illusion of not having failings and not being in need, they fear that the admission of guilt or dependency exposes something unacceptably shameful. Sincere apologies and heartfelt thanks, the behavioral expressions of remorse and gratitude, may thus be avoided or compromised in narcissistic people, to the great impoverishment of their relationships with others.

By definition, the assessment of narcissistic personality organization conveys that the client needs external affirmation in order to feel internal validity. Theorists diverge rather strikingly in whether they stress the grandiose or the depleted aspects of narcissistic self-experience, a difference of emphasis central to the disagreement between Kernberg and Kohut on how to understand and treat narcissistic characters, about which I say more later. Disputes on this question go back at least as far as differences of opinion between Freud (1914b), who stressed the individual's primary love of self, and Alfred Adler (1927), who emphasized how narcissistic defenses compensate for feelings of inferiority. Which came first in the evolution of pathological narcissism, the grandiose self-state or the depleted, shamed one, may be the psychoanalytic equivalent of a chicken-egg riddle. From a phenomenological standpoint, these contrasting ego states are intimately connected, much as depression and mania are opposite sides of the same psychological coin.

TRANSFERENCE AND COUNTERTRANSFERENCE WITH NARCISSISTIC PATIENTS

The transference environment with narcissistic clients feels qualitatively different from what one feels with clients who lack pathological narcissism. Even the highest-functioning, most cooperative person with a narcissistic character may contribute to an ambiance in the therapeutic relationship that contrasts sharply with the atmosphere that emerges between the therapist and other clients. Typically, the therapist first notices the patient's lack of interest in exploring the therapeutic relationship. The early psychoanalysts noted this and concluded that narcissistic patients did not have transferences because all their libidinal energy was directed toward the self; this was another basis for doubting that they were treatable. Contemporary analytic theory acknowledges that narcissistic clients do have transference reactions but of a different sort from those of other patients.

Inquiries into how the client is feeling toward the clinician may be received as distracting, annoying, or irrelevant to the client's concerns. It is not unusual for narcissistic patients to conclude that the therapist is asking about their experience of the therapeutic relationship out of conceit or a need for reassurance. (Such silent hypotheses may be projections, of course, even if true, but they tend to be un verbalized, and they can rarely be usefully addressed, at least early in treatment.) This does not mean that narcissistic patients lack strong reactions to the therapist. They may devalue or idealize intensely. Yet they are curiously uninterested in the meaning of those reactions and are

genuinely confused about why the clinician is asking about them. Their transferences may be so ego syntonic as to be inaccessible to exploration. A narcissistic patient may believe he or she is devaluing the therapist because the therapist is objectively second-rate or idealizing the therapist because the therapist is objectively wonderful. Efforts to make such reactions ego alien will usually fail, at least initially: The devalued practitioner who comments on the patient's critical attitude will be perceived as defensive, and the idealized one who comments on the patient's overvaluation will be further idealized as someone whose perfection includes an admirable humility.

Beginning therapists get a lot more devaluing transferences than idealizing ones. It may be some consolation for the misery one endures at being the object of subtle and relentless disparagement that being the recipient of a narcissistic idealizing transference is not much better. In both circumstances one may feel that one's realistic existence as a human being with some emotional intelligence, who is sincerely trying to help, has been extinguished. In fact, this countertransference sense of having been obliterated, of having been made invisible as a real person, is diagnostic of a probable narcissistic dynamic.

Related to these phenomena are countertransferences that include boredom, irritability, sleepiness, and a vague sense that nothing is happening in the treatment. A typical comment about a narcissistic client from a therapist in supervision: "She comes in every week, gives me the news of the week in review, critiques my clothing, dismisses all my interventions, and leaves. Why does she keep coming back? What is she getting out of this?" A strange sense that one does not quite exist in the room is common. Extreme drowsiness is perhaps the most unpleasant of the countertransference reactions to narcissistic patients; every time I experience this, I find myself generating biological explanations ("I didn't get enough sleep last night"; "I just ate a big lunch"; "I must be coming down with a cold"), and then once that patient is out the door and another one is inside, I am wide awake and interested. Occasionally one's countertransference to an idealizing person is a sense of grandiose expansion, of joining the patient in a mutual admiration society. But unless the therapist is also characterologically narcissistic, such reactions are both unconvincing and short-lived.

The psychoanalytic explanation for these phenomena relates to the special kind of transference characteristic of narcissistic people. Rather than projecting a discrete internal object such as a parent onto the therapist, they externalize an aspect of their self. Specifically, instead of feeling that the therapist is like mother or father (although sometimes one can see aspects of such transferences), the client projects either the grandiose or the devalued part of the self. The therapist thus becomes a container for the internal process of self-esteem maintenance. He or she is a selfobject, not a fully separate person who feels to the patient like a previously known, well-delineated figure from the past.

To be used for a self-esteem maintaining function rather than perceived as a separate person is disconcerting, even unnerving. The dehumanizing effect of the narcissistic person's attitude accounts for some of the negative countertransference reactions therapists have described in

connection with treating such clients. Yet most therapists also report that they can tolerate, control, and derive empathy from such internal reactions once they understand them as comprehensible and expectable features of working with narcissistic patients. The disposition to feel flawed as a therapist is a virtually inevitable mirror of the patient's core worries about self-worth; it is relieving to substitute a revised clinical formulation for ruminations about what one is doing wrong.

Heinz Kohut and other analysts influenced by the self psychology movement (e.g., Bach, 1985; Buirski & Haglund, 2001; Rowe & MacIsaac, 1989; Stolorow, Brandchaft, & Atwood, 1987; E. S. Wolf, 1988) have described several subtypes of selfobject transferences that may appear in narcissistic patients, including mirroring, twinship, and alter-ego patterns, and many scholars have found parallels between these concepts and contemporary infant research (Basch, 1994). Although I cannot do justice to the complexity of such ideas here, readers who find that the description of narcissistic personality fits a patient they have previously been construing some other way may find it helpful to explore the language of self psychologists for conceptualizing their clients' experience.

THERAPEUTIC IMPLICATIONS OF THE DIAGNOSIS OF NARCISSISM

A therapist who is able to help a narcissistic person to find self-acceptance without either inflating the self or disparaging others has done a truly good deed, and a difficult one. A primary requisite for treating narcissistic pathology is patience: No one with a track record for influencing the psychology of narcissistic patients has done it very fast. Although modification of any kind of character structure is a long-term undertaking, the requirement of patience may be more keenly felt with narcissistic clients than with those of other character types because of one's having to endure countertransference reactions of boredom and demoralization.

Because there are competing theories of etiology and therapy, it is hard to summarize psychodynamic wisdom about treating narcissistic patients. Most arguments are variants on a complex disagreement between Kohut and Kernberg that appeared in the 1970s and 1980s. The gist of their respective positions was that Kohut (1971, 1977, 1984) saw pathological narcissism developmentally (the patient's maturation was going along normally and ran into some difficulties in the resolution of normal needs to idealize and deidealize), while Kernberg (1975, 1976, 1984) viewed it structurally (something went askew very early, leaving the person with entrenched primitive defenses that differ in kind rather than in degree from normality: "Pathological narcissism reflects libidinal investment not in a normal integrated self-structure but in a pathological self-structure [1982, p. 913]). Kohut's conception of a narcissistic person can be imaged as a plant whose growth was stunted by too little water and sun at critical points; Kernberg's narcissist can be viewed as a plant that has mutated into a hybrid.

A consequence of their differing theories is that some approaches to narcissism stress the need

to give the plant plenty of water and sun so that it will finally thrive, and others propose that it must be pruned of its aberrant parts so that it can become what it should have been. Those more responsive to Kohut's formulation (e.g., 1971, 1977) recommend benign acceptance of idealization or devaluation and unwavering empathy for the patient's experience. Kernberg (e.g., 1975, 1976) advocates the tactful but insistent confrontation of grandiosity, whether owned or projected, and the systematic interpretation of defenses against envy and greed. Self psychologically oriented therapists try to remain inside the patient's subjective experience, whereas analysts influenced by ego psychology and object relations theory oscillate between internal and external positions (see Gardner, 1991).

Most analysts I know have patients for whom Kohut's formulations, both etiological and therapeutic, seem to fit and others for whom Kernberg's seem apt. Kernberg has suggested that Kohut's approach might be considered a subtype of supportive therapy, and hence appropriate for narcissistic patients in the borderline-to-psychotic range (even though Kohut's clinical work, unlike Kernberg's, was mostly with high-functioning patients). This idea is implicitly endorsed by many of my colleagues, who say they find Kohut's recommendations applicable to their more disturbed and depressed-depleted narcissistic clients. Because the jury is still out on the dispute, and because readers can consult the original sources for recommendations about overall approach, I offer some general suggestions on the treatment of narcissism that exist outside this controversy.

I have already mentioned patience. Implicit in that attitude is an acceptance of human imperfections that make therapeutic progress a tedious and taxing business. The matter-of-fact assumption that we are all imperfect and resistant to change contrasts sharply with what the narcissistic person has internalized. Such an attitude is humane and realistic rather than critical and omnipotent. Some therapeutic mileage is already inherent in such a position. Although humility is important to all clinical work, it is particularly critical when one works with narcissistic patients that therapists embody a nonjudgmental, realistic attitude toward their own frailties.

One of Kohut's greatest contributions to practice (Kohut, 1984) was his attention to the consequences of the therapist's acknowledgment of errors, especially of lapses in empathy. According to the ego psychologists who preceded him (e.g., Greenson, 1967), a therapist's mistake need not impel any activity other than private reflection; the patient is simply encouraged, as always, to associate to what happened and to report any reactions. Even Carl Rogers (1951), who had advocated a style almost identical to Kohut's later recommendations (Stolorow, 1976), seems not to have assumed, as Kohut did, that well-meaning therapists would inevitably inflict narcissistic injuries on clients. Thus, client-centered therapy did not address whether to acknowledge such errors—though I read Rogers's principle of authenticity as implying that they should. Self psychologists have called our attention to how devastated a narcissistic person can be by a professional's failure of empathy, and how the only way to repair such an injury is by expressing regret. An apology both confirms the client's perception of mistreatment (thereby validating his or her real feelings rather than furthering the insincere compliance with which narcissistic people are

used to operating) and sets an example of maintaining self-esteem while admitting to shortcomings.

It is important not to become excessively self-critical when acknowledging one's inevitable errors. If the patient perceives that the therapist is in an agony of remorse, the message that may be received is that mistakes should be rare and require stern self-censure—a delusion from which the narcissistic person is already suffering. It is better to take one's cue from Winnicott, who is reputed to have fielded a query about his rules for interpretation with the comment: "I make interpretations for two purposes. One, to show the patient that I am awake. Two, to show the patient that I can be wrong." Similarly, Arthur Robbins (personal communication, April 1991), a psychoanalyst with expertise in art therapy and other expressive modes of treatment, describes his theory of technique as "Fuck-up therapy: I fuck up, and the patient corrects me." Contemporary relational writing (e.g., Kieffer, 2007), drawing on research with infants (Beebe & Lachmann, 1994), emphasizes the centrality to all therapy of what Kohut (1984) deemed the inevitable "rupture and repair" process; I think this process is especially central to the treatment of people with characterological narcissism.

Attempts to help a narcissistic patient also require a constant mindfulness of the person's latent self-state, however overwhelming the manifest one is. Because even the most arrogant, entitled narcissist is subject to excruciating shame in the face of what feels like criticism, therapists must take pains to frame interventions sensitively. True mutuality with narcissistic clients is tenuous because they cannot tolerate circumstances in which their fragile self-esteem is diminished. Their early reputation for being impossible to treat derived partly from analysts' experience with their abruptly terminating therapies of even several years' duration when their feelings were hurt.

I have mentioned the power of shame in the experience of the narcissistic person, and the value of the therapist's discriminating between shame and guilt. People with fragile self-esteem may go to great lengths to avoid acknowledging their role in anything negative. Unlike people who easily feel guilty and who handle their transgressions with efforts at reparation, narcissistically motivated people run from their mistakes and hide from those who would find them out. They may induce in therapists either a disposition to confront them unempathically about their own contributions to their difficulties or a tendency to join them in bemoaning the bad deal they have gotten from others. Neither position is therapeutic, although the second is temporarily palliative to a person who otherwise may suffer chagrin bordering on mortification.

Because of their devastation when their imperfections are visible, narcissistic individuals tend to use obfuscating language that implicitly disowns personal responsibility ("Mistakes were made"). The therapist faces the daunting task of expanding the narcissistic patient's awareness of, and honesty about, the nature of his or her behavior without stimulating so much shame that the person either leaves treatment or keeps secrets. One way to do this in the context of a client's complaints and criticisms about others is to ask, "Did you make your needs explicit?" The rationale for this query is that narcissistic people have deep shame about asking for anything; they believe that to admit a need exposes a deficiency in the self. They consequently get into situations where they are miserable because another person does not effortlessly divine their needs and offer what

they want without their suffering what they see as the humiliation of asking. They often try to persuade the analyst that their problem is that the people they live with are insensitive. A question about articulating needs may gently expose a narcissistic patient's belief that it is shameful to need someone and may create opportunities to learn something different about human interdependency.

I noted earlier the difference between selfobject and object transferences. An implication of this difference is that therapists treating narcissistic clients cannot fruitfully investigate their transference reactions as they would those of other people. Questions about who we are to the patient tend to fall flat; interpretations along the lines of "Maybe you're experiencing me as like your mother right now" may be received as pointless distractions. Therapists need to know that despite the countertransference feeling that one means nothing to the patient, a narcissistic person often actually needs the therapist more than do people without significant self-esteem deficits. It can be stunning to therapists inexperienced with narcissistic patients to learn that the same person who renders them insignificant and impotent during therapy sessions is quoting them admiringly outside the consulting room. Even the arrogant, boastful, seemingly impervious patient betrays a deep dependency on the therapist by his or her vulnerability to feeling crushed when the therapist is insensitive. In working with narcissistic people, practitioners have to become accustomed to absorbing a great deal that they would address with other types of patients.

DIFFERENTIAL DIAGNOSIS

Injuries to self-esteem may lead anyone to behave temporarily like a narcissistic character. Moreover, all types of personality structure have a narcissistic function: They preserve self-esteem via certain defenses. But to qualify as characterologically narcissistic, one must have longstanding, automatic, and situation-independent patterns of subjectivity and behavior. Narcissistic personality organization seems currently overdiagnosed, perhaps especially by psychodynamic clinicians. The concept is often misapplied to people having situation-specific reactions and to psychopathic, depressive, obsessive compulsive, and hysterical personalities.

Narcissistic Personality versus Narcissistic Reactions

I have already suggested one caveat in diagnosing characterological narcissism: Even more than with other psychological conditions to which all human beings are vulnerable, narcissistic concerns are ubiquitous and can easily be situationally incited. Kohut and Wolf (1978) referred to individuals who (like the Chinese graduate student mentioned in the Introduction to this part) confront circumstances that challenge their prior sense of identity and undermine their self-esteem as suffering from a "secondary narcissistic disturbance," not a narcissistic character disorder. It is an important distinction. Any non-narcissistic person can sound arrogant or devaluing, or empty and idealizing, under conditions that strain his or her identity and confidence.

Medical school and psychotherapy training programs are famous for taking successful, autonomous adults and making them feel like incompetent children. Compensatory behaviors like bragging, opinionated proclamations, hypercritical commentary, or idealization of a mentor are common under such circumstances. Phenomena like these are sometimes referred to in the psychoanalytic literature as comprising a “narcissistic defense” (e.g., Kernberg, 1984). That one is suffering with narcissistic issues does not make one a narcissistic personality. Where situational factors dominate a narcissistic presentation, the interviewer should rely on historical data and the feel of the transference to infer the personality structure underneath the narcissistic injury.

Narcissistic versus Psychopathic Personality

In the last section of the previous chapter, I mentioned the importance of discriminating between a predominantly psychopathic personality structure and one that is essentially narcissistic. Kohutian efforts at empathic relatedness, at least as they are conventionally put into practice, would be ineffective with psychopathic people because they do not emotionally understand compassionate attitudes; they scorn a sympathetic demeanor as the mark of weakness. The approach advocated by Kernberg (e.g., 1984) centering on the confrontation of the grandiose self, would be more respectfully assimilated by a psychopathically organized person, and is consistent with the recommendations of therapists such as Greenwald (1974), Bursten (e.g., 1973a, 1973b), Groth (e.g., 1979), and Meloy (e.g., 2001), who have specialized in working with psychopathic clients.

Narcissistic versus Depressive Personality

The more depressed kind of narcissistic person can easily be misunderstood as having a depressive personality. The essential difference between the two groups is, to condense a great deal of clinical theory and observation into a simple image, that narcissistically depressed people are subjectively empty, whereas depressive people with introjective psychologies (Blatt, 2004) (those who used to be described as suffering depression of the more “melancholic” or guilty type) are subjectively full—of critical and angry internalizations. The narcissistic depressive feels devoid of a substantial self; the melancholic depressive feels the self is real but irreducibly bad. I comment on these differences and their divergent therapeutic implications more in [Chapter 11](#).

Narcissistic versus Obsessive–Compulsive Personality

It is easy to misconstrue a narcissistic person as obsessive and/or compulsive on the basis of the attention to detail that may be part of the narcissistic quest for perfection. In the early days of psychoanalytic practice, fundamentally narcissistic people were often considered obsessive or compulsive because their presenting symptoms fell into one or both of those categories. They were then treated according to assumptions about the etiology of obsessive–compulsive character that emphasized struggles for control and guilt over anger and fantasied aggression.

Narcissistic patients, who were empty more than angry, did not make much progress in that kind of therapy; they would feel misunderstood and criticized when the therapist seemed to harp on issues that were not central to their subjectivity. Although many people have both narcissistic and more classically obsessive concerns, those whose personalities were predominantly narcissistic tended to get little help from analytic therapy before the 1970s, when theories of the etiology and treatment of pathological narcissism radically extended our capacity to help people with disorders of the self. I know of a number of people treated analytically before that time who still bear grudges against their therapist and against psychoanalysis in general. In popular accounts of psychotherapy experiences one can find what seem to be examples of the effects of this misdiagnosis. I give more details on this distinction and the implications of this diagnostic error in [Chapter 13](#).

Narcissistic versus Hysterical Personality

While the narcissistic versus obsessive–compulsive personality differential is called for somewhat more frequently with men than with women, the need to distinguish between narcissism and hysteria comes up much more commonly with female patients. Because hysterically organized people use narcissistic defenses, they are readily misinterpreted as narcissistic characters. Heterosexual women whose hysterical presentation includes considerable exhibitionistic behavior and a pattern of relating to men in which idealization is quickly followed by devaluation may appear to be basically narcissistic, but their concerns about self are gender specific and fueled by anxiety more than shame. Outside certain highly conflicted areas, they are warm, loving, and far from empty (see Kernberg, 1984).

The import of this differential lies in the contrasting therapeutic requirements for the two groups: Hysterical patients thrive with an attention to object transferences, whereas narcissistic ones require an appreciation of selfobject phenomena. In [Chapter 14](#) I go into more detail on this topic.

SUMMARY

This chapter has described the depleted subjective world of the person with a narcissistically organized character and the compensatory behaviors with which such a person tries to maintain a reliable and valued sense of self. I have emphasized the affects of shame and envy, the defenses of idealization and devaluation, and relational patterns of using and being used to equilibrate one's self-esteem and to repair damage to it. I discussed the narcissistic person's propensity for selfobject transferences and noted countertransference reactions in which a sense of unrelatedness prevails. I mentioned some implications for technique that derive from an appreciation of these special aspects of the narcissistic condition, although I acknowledged current controversies in the psychoanalytic understanding of narcissism that make effective approaches with this population a matter of some dispute. Finally, I distinguished narcissistic character organization from narcissistic reactions, from

psychopathy, from introjective depressive personality, from obsessive and compulsive character structure, and from hysterical psychology.

SUGGESTIONS FOR FURTHER READING

There has been a voluminous psychoanalytic literature on narcissism since the 1970s, when Kohut published *The Analysis of the Self* (1971) and Kernberg offered an alternative conception in *Borderline Conditions and Pathological Narcissism* (1975). Both these books contain so much jargon that they are almost impossible for someone new to psychoanalysis to read. More manageable alternatives include Alice Miller's *Prisoners of Childhood* (1975) (known in another edition as *The Drama of the Gifted Child*), Bach's *Narcissistic States and the Therapeutic Process* (1985), and Morrison's *Shame: The Underside of Narcissism* (1989). Morrison also edited a collection, available in paperback, titled *Essential Papers on Narcissism* (1986), which contains major psychoanalytic essays on the topic, most of which are excellent. For a scholarly analysis of the cultural trends behind the "empty self" that is central to narcissistic personality, see Philip Cushman's *Constructing the Self, Constructing America* (1995).

Newer works on narcissism tend to be based on the description in DSM-IV, and thus strike me as more superficial, trait based, and one-dimensional than these analytic writings. But the oversimplification and popularization of a concept can have its advantages: There are now many helpful popular books for individuals coping with narcissistic parents, lovers, colleagues, employers, and other difficult people.