ENGENDERING NARCISSISM: A QUALITATIVE STUDY OF THE EXPERIENCE OF GENDER IN MEN AND WOMEN WITH NARCISSISTIC PATHOLOGY

by

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Abstract

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ANNA KRAMARSKY

Advisor: Professor Diana Diamond

This qualitative study examines the relationship between gender and narcissism through interviews with psychoanalysts about their work with men and women with narcissistic pathology. The study found that there were conflicted, ambivalent experiences of gender in many patients with narcissistic disorders. There are two significant expressions of this gendered ambivalence: struggles in the physical body and interpersonal struggles based in an ideal version of what it means to be male or female. The first involves a physical sense of oneself as not fully male or female. The men in this group have a preponderance of feminine identifications along with masculine identifications and experience gender confusion. Their conflict about their masculinity is frequently expressed in feelings in and about their bodies. The women in this first set tend to have deficient female identifications that manifest themselves in the experience of their bodies as faulty or damaged. The second expression

of gender ambivalence tends to manifest itself in relation to others, including the analyst, and involves an idealized version of masculinity and/or femininity. In both groups the struggles include gendered issues of subjectivity, power, aggression, dependency and creativity. Early family dynamics appear to play a role in the development and expression of gendered conflict. For those patients with embodiment issues there tends to be an intrusive parent. For those with an interpersonal expression parents tend to be hyper-critical or neglectful. Struggles in the realm of gender play out in the treatment and are important in understanding the transference and countertransference dynamics.

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Chapter One: Introduction

In this thesis I will explore the relationship and interaction between narcissism and gender through an analysis of psychoanalysts' understandings of the experience of gender ambivalence and early gendered struggles in patients with narcissistic disorders. I became interested in the role of gender in narcissistic pathology through my own work with patients with narcissistic disorders and the work of my peers with such patients. As I reviewed the literature, I found there was very little written specifically about narcissism and gender, and so I approached psychoanalysts with many years of clinical experience with patients with narcissistic disorders, to discuss the issues and discern how they understand the relationship between narcissistic pathology and gender. I developed an open-ended interview and asked seven experienced psychoanalysts to describe their work with a male and a female patient with narcissistic pathology, and then to consider issues of gender in the pathology. What emerged from these diverse experts' experience was a concentration of very rich issues for further exploration. Specifically, the experience of being gendered—either the physical experience of being male or female or the symbolized experience of feeling masculine or feminine—is a struggle for many of the patients the analysts discussed.

These struggles were described in patients with a wide range of functioning by analysts with different theoretical orientations. In this thesis, I present material from those interviews to illuminate the specific nature of the conflicts as they presented in this subset of patients. I focus on the analysts' summaries of patients' struggles with embodiment, subjectivity, aggression, object need/use, martyrdom and body-perfection as well as their particular struggles in treatment as presented by their analysts. I explore these specific dimensions of narcissistic character pathology, and ground them in terms of their gendered components, and in the context of early conflicts and family dynamics. I will also discuss how conflicted gendered experiences play out in the treatment, in the struggles of and with the analyst, and in the experiences of transference and countertransference.

The Personal Perspective of this Inquiry

My interest in the role of gender in narcissistic pathology stems from my work with two adult patients, one male and one female, in twice-weekly psychoanalytically informed psychotherapy. I consider both of these people to have significant narcissistic pathology. Each of them has a fantasy of perfection, which makes them unable to tolerate the frustrations of life. Neither of them has a sense of self in which the good and the bad parts of themselves have

been integrated, nor can they relate to others as complex people. They differ in presentation, but they share these core struggles of how they feel in their selves and how they relate to others. I will briefly describe them to highlight their different presentations.

"I have always thought I should have a gold-domed ceiling in my bedroom" (Mark, Spring 2003, discussing his wish to redo his apartment to make it suit him.)

Mark is a 38-year-old man who came to treatment twelve years ago and was transferred to me after four years with another therapist. When we began treatment, Mark denied any transference experience and believed the only discontinuity in the treatment was that his previous therapist is a man and I am a woman. He could not articulate what that might mean to him or to the therapy, but this was the one distinction he drew. Otherwise, he appeared to believe that if the room and the session time remained the same, his shift from his previous therapist to me would be inconsequential. At the time of the transfer, Mark gave no history and no introductions to the people to whom he referred and seemed angry and confused if I asked questions.

Mark presented as grandiose and overly entitled, and he prided himself on being intense and aggressive. In sessions, he regularly raged against "faggots," homeless

people and women, and he fantasized about being the type of man who could kill someone. His fantasized hyper-masculine prowess felt in opposition to his sense of himself as liberal, sensitive and thoughtful. Throughout the therapy Mark has presented an idea of who he should be and what men should be like, but he struggles to live up to this idea and finds it hard to experience his actual life and find a masculinity that feels authentic.

Mark describes a self-involved, controlling mother who does not "know" him and a transgendered, mentally ill father from whom he fears contamination. Although Mark is upset and often disorganized by his parents, he continues to be very involved with them. Until recently, Mark lived in his mother's apartment and was financially and emotionally dependent on her. He describes having to "follow her program" and being unable to be himself or follow his interests. Mark has twice remarked that he and his mother "need couple's counseling." Mark's father left when Mark was young, but he has stayed in touch. After years of cross-dressing, Mark's father had sex-reassignment surgery and Mark began one session, soon after the surgery, with the statement, "there is something wrong with my father's vagina." Mark now lives with his father and is developing a closer relationship to him (he continues to refer to this parent in the masculine), but he is afraid to know too much for fear of becoming somehow overwhelmed by his father's

issues.

Mark's narcissistic issues are evident in his struggles in his relationships, his work and his experience of school and his inability to "move forward." He has had a series of long-term girlfriends and is now engaged, but he is often disappointed in these women and has trouble having sex with them (although he has been sexually promiscuous with friends in the past). Mark has also struggled to find work that feels satisfying, and he is frequently caught between his fantasies of enormous success and the disappointment of having to work. Mark continues to struggle with what it means to be "a full time grown up" and more specifically what it means to be a man. In the treatment, Mark's original acknowledgement, "you are a woman, and [my previous therapist] was a man" has taken on new depth and meaning and revealed itself to be an important and complicated issue for Mark, as the question of what it is to be the right kind of man is so central to his struggles. Mark has become more related and is more able to tolerate frustration, but his sense of self is still easily disrupted and he retreats to grandiose fantasy when he is anxious. Mark's fantasy of becoming a hugely successful, fully independent man makes his smaller achievements much harder for him to experience with pleasure.

"I copy. I am not one person. I am whoever they want me to

be. I adapt." (Marisol, Fall 2002, describing her experience of herself.)

Marisol is a 31-year-old divorced woman who came to treatment for intermittent depression and difficulties with her then husband. She was academically and professionally successful, but felt she had never made a decision in her life. Marisol described herself as the sanest member of a "dysfunctional" family with a distant, philandering father and an unbounded, invasive mother so consumed by her own chaos that she was both overwhelming and rejecting. Marisol presented as sweet and unassuming. She described herself as the person everyone talks to, the one who will do anything for anyone, the perfect friend. She felt the need to live up to a feminine ideal of goodness and beauty and had had repeated plastic surgeries (one was a wedding present from her husband) to meet that ideal.

Marisol describes a childhood of being overly involved with her parents and being neglected and left out. Her mother appears to have been both fragile and overbearing and to have used Marisol to fulfill her own needs. Marisol slept in the same bed with her mother after her father left, and her mother used her as her closest confidant, but her mother also forgot about her at times, leaving her alone waiting outside for hours. Marisol thus has trouble both with being close and with being separate. She struggles

with both the mother of merger and bliss and the mother of separation, with self-constancy and object constancy. Her primary anxieties appear to stem from fears of object loss and loss of maternal love. These manifest in her fear that she will be forgotten and her complaints of feeling empty and bored. Marisol attempts to use her relationships to gain power and feel whole, but she then feels herself to be at the whim of her objects, controlled by them because she must always "adapt." Marisol says she has never chosen anything. She feels she cannot express her agency or aggression and must be "soft."

Marisol's narcissistic issues are evident in her over-investment in an ideal of herself and an over-valuation of the opinions/desires of others. She experiences herself as an object for others to manipulate and yet, underneath that surface of soft femininity, she is enraged, and feels tremendously powerful and special.

Mark and Marisol's presentations are very different. Marisol presented as martyred, sweet and successful, while Mark presented as provocative, aggressive and actively struggling. But both are primarily narcissistic. Both defend against dependency and fear abandonment. Both see those around them as extensions of themselves and are therefore unable to have full relationships. In treatment, Mark's fear that he is nothing emerged and Marisol's fantasy

of omnipotence became clear, but, working with them, I have continued to struggle to be aware of his attachment and sadness, while with her I have needed to remind myself of her aggression and the false perfection of some of her attachments.

As I thought about these two patients, and as I heard other cases presented by my colleagues, I became interested in the role gender had played in the development and expression of their narcissistic pathology. I began to wonder about the role of gender in my patients' experiences of mothering, their expressions of grandiosity, their levels of expressed aggression and their use of sexual relationships and the body. I considered, was the complementarity of their situations merely serendipitous, or does gender generally play a specific role in the development and expression of narcissistic pathology? I determined to interview psychoanalysts to obtain their condensed experience of specific cases and used my questions as the basis of the interviews.

As I spoke with analysts about their patients another element emerged, and I became interested in understanding not only the role of gender and early gendered experiences in narcissistic pathology, but the role of the narcissism in the experience of gender, and the early gendered experiences that lead to both narcissistic struggles and gender

conflicts. I did not ask the analysts to discuss patients with conflicts about their gender, only to discuss two patients with narcissistic pathology, one male, and one female. However, when focusing on narcissism, the analysts repeatedly told the stories of patients with a complex and ambivalent experience of maleness and femaleness. These gendered issues are essential in understanding Mark and Marisol as well. Mark is not really sure of his masculinity and Marisol's struggles involve keeping up her idea of an ideal body and intact her sense of herself as lovable, people pleasing and feminine. And so, drawing on the literature, the analysts' experience and my own work, this thesis explores the experience of gender itself in patients with narcissistic disorders and considers how a narcissistic experience of gender is expressed in the body and in relation to others. Understanding a narcissistic experience of gender is vital to developing a theory of narcissism as a gendered pathology, in its origins and its expression.

Theoretical considerations

Narcissism has a complicated history in the analytic world and there is much disagreement about the disorder in the field. Analytic theories of narcissism continue to contest the development and etiology of the disorder, its manifestations, and the primary area of disruption. Some theorists argue that the disorder is a fixation or a

regression to an infantile stage (Kohut, 1986) while others argue it is a separate line of development (Freud, 1986; Kernberg, 1975). Some focus on preoedipal conflicts (Grunberger, 1989; Kohut, 1986; MacDougal, 1991), while others suggest that Oedipal dynamics are also important (Bach, 1988; Kernberg, 1975; Reich, 1960); some define narcissism as a disorder of the self (Kohut, 1986), others as a disorder of self-structure and object relations (Kernberg, 1984; Reich, 1954). There is also no unified view of the manifestations of the disorder, and there is disagreement on the role of the infant's innate aggression, the role of castration anxiety and the importance of the real experience of the parent. However, considering each of these areas of discord, it is likely that gender plays a role in the development and manifestation of the disorder as the gender of the child influences: the experience of conflict in psychosexual stages, parental identifications necessary to develop self-representation, concerns about castration and possibly even the level of aggression.

Studies have shown that the gender of the patient does influence diagnosis when using the current psychiatric definition of Narcissistic Personality Disorder. The Diagnostic and Statistical Manual of the American Psychiatric Association (DSM IV; 1994) defines Narcissistic Personality Disorder as "a pervasive pattern of grandiosity, need for admiration, and lack of empathy" (p.658). The DSM

reports that up to 75% of those with Narcissistic Personality Disorder are men. There seem to be two forms of gender bias in this diagnosis. Empirical studies have shown that among patients with similar configurations of character, men tend to be diagnosed with Narcissistic Personality Disorder and women tend to be diagnosed with Borderline Personality Disorder (Haaken, 1983). It also seems likely that the greater prevalence of DSM IV Narcissistic Personality Disorder in men is an artifact of the focus on overt grandiosity, rather than other forms of the disorder, as extremely high self-regard and grandiosity seem more socially acceptable in men than in women.

Although only this grandiose form is codified psychiatrically, other expressions of narcissistic disorders are recognized clinically and have been empirically validated. These include types referred to as dependent, craving, covert, overburdened, vulnerable and hypersensitive narcissists (Bach, 1985; Bursten, 1986; Cooper, 1998; Diamond, in press; Miller, 1986; O'Leary & Wright, 1986; Wink, 1991). From work with non-clinical populations, some suggest that those with more covert narcissistic pathology are more disturbed as they are constantly experiencing their inadequacies (Rose, 2002). Clinicians suggest that women tend to present with the more dependent, hypersensitive narcissistic pathology. Furthermore, patients who have a more covert form may often be missed diagnostically

(Dickinson & Pincus, 2003) further skewing the gender ratio of the diagnosis.

Arguably, the differences in presentation between male and female patients with narcissistic pathology that is seen by clinicians may be due, in part, to the social structure and societal norms of our culture. However, as Diamond (in press) explains, “character development always results from an eminent adaptation between culturally-fostered patterns on the one hand, and the imperatives of the intrapsychic world of drive, affect and object relations on the other”(p. 3). As the social and economic dimensions of gender roles change, clinicians may see fewer clear gender distinctions in the presentation of narcissistic pathology, or an increase in gender fluidity may aggravate the gendered dimensions of narcissistic pathology. Whatever the outcome of societal shifts, the intrapsychic world is influenced by the gendered experiences of development, identifications and separations that are core to our culture and therefore will persist despite superficial change (Person, 1990; Rubin, 1975). It is, therefore, vital to understand the gendered roots and routes of the pathology and to consider the full range of difficulties in self-esteem regulation and object relations in both men and women suffering from pathological narcissism.

The complexities of gendered experience

What emerged in this investigation is that not only does being a boy or a girl seem to influence the development of narcissistic pathology and how it is eventually expressed, but that the experience of gender itself is implicated in the disorder so that how the narcissistic adult experiences his or her maleness or femaleness is frequently disturbed. These findings make sense in light of the complexity of gender and the role of gender in the development of self. Dimen (1991) explains, “problems of the self may come to be coded in terms of gender, and those of gender, in terms of the self” (p.337). Moreover gender, as a core part of identity, seems to be implicated in some of the disruptions that lead to narcissistic issues. For some of the cases presented by the psychoanalysts there appears to be a rigid gendering of the ideal self, while for others there seems to be an issue of self-other differentiation that inhibits a clear gendering. Freud understood the experience of masculinity and femininity to reside in the individual’s experience of difference, and cautioned that “it is important to understand clearly that the concepts of ‘masculine’ and ‘feminine,’ whose meaning seems so unambiguous to ordinary people, are amongst the most confused that occur in science” (1993 [1905]; p.1). This study explores the ambiguities of masculinity and femininity in patients with narcissistic disorders, as understood by their psychoanalysts, in order to develop a

better understanding of the relationship between gendered experience and narcissistic pathology.

Chapter Two: Literature Review

The goal of this research is to develop a better understanding of the intersections of gender and narcissism through an exploration of the experiences of gender in patients with narcissistic disorders, as represented by their psychoanalysts. I consider the role of gender in the etiology and manifestation of different forms of narcissistic disorders, the experience of being male or female for narcissistic men and women, and the gendered struggles that emerge in treatment with patients with narcissistic pathology.

Overview of Literature Domains

I will review four areas of the literature that are relevant to this work. I will review theories of narcissism to understand some of the historical and current thinking about the disorder, its expression, its meaning and its etiology. I will also discuss inadequacies of the psychiatric diagnosis and questions that arise in different psychoanalytic schools. I will review some developmental theories, focusing on early attachment and the separation – individuation process for material on the role these phenomena play in the development of gender and narcissistic character pathology. I will discuss theories of gender difference in order to understand the relationship between

gender and the etiology and expression of narcissistic pathology. In this section, I will focus especially on the role of the body and the use of the body as a narcissistic tool. I will also review the psychoanalytic literature on transference and countertransference dynamics in work with patients with narcissistic pathology. These areas of literature are not distinct or exclusive and each domain draws on and references the others, so the themes and issues will be recalled and interwoven throughout the chapter, as each is explored.

Narcissism

The literature on narcissism does not offer a unified understanding of the concept. There appear to be many forms of the disorder, as well as many different conceptions of the pathology and its etiology. As with all psychoanalytic diagnoses, these theories are ways to understand and codify clinical phenomena, and more recent work suggests that perhaps there divergences are due, in part, to the different types of the disorder on which they are based (Broucek, 1982). Narcissism is a widely written about, and I have chosen to discuss only a few key theorists in this section to give a sense of the divergence and the similarities in the theoretical constructions.

Defining narcissism

The term narcissism was first used by Paul Nacke “to denote the attitude of a person who treats his own body in the same way in which the body of a sexual object is ordinarily treated” (Freud, 1986 [1914], p.17). Since that time, many theories have developed to explain the manifestations and roots of the pathology. They stress different poles of the disorder, grandiosity or deflation, and whether the pathology is seen to reside primarily in the object relational field or in the self-structure.

In *On Narcissism*, Freud (1986 [1914]) posits a normal “primary narcissism” and a more pathological “secondary narcissism.” Primary narcissism refers to an infant’s libidinal cathexis in the as-of-yet undifferentiated ego. In normal development, as the infant begins to separate from the mother, this state of symbiotic pleasure changes and libidinal investment shifts from ego to objects. The mother or mother substitute becomes the first love object, an “attachment-type” love object. When there is a disturbance in development, a secondary narcissism may form in which the libido is withdrawn from objects and turned again onto the ego or onto objects internalized by the ego; the love object is modeled on the self, not the mother. Freud suggests that both these object choices are possible for most people, but one is generally more predominant.

Reich (1960), like Freud, posits that narcissism denotes libidinal cathexis of the self rather than the

object, but she suggests that the withdrawal of cathexis from the object may not be complete. Reich (1954) argues that normal narcissism is an early state of undifferentiation, but pathological narcissism is an ongoing imbalance of cathexis and/or an infantile form of narcissism which persists rather than being integrated into a healthy ego and super-ego structure. She explains that the reliance on narcissistic ideals can stem from sudden threats to narcissistic intactness (p. 220). Reich (1960) argues that self-esteem is a problem for narcissists because they can never live up to their unattainable ego-ideals. They therefore develop pathological forms of self-esteem regulation, like compensatory narcissistic self-inflation, but these methods frequently fail and, instead of creating "narcissistic bliss," they result in severe symptoms (p. 218).

Kernberg (1984) defines narcissism as a disorder of the self-structure that is connected to a disturbance of object relations. The self-structure contains affective and cognitive components and is embedded in the ego but is derived from intrapsychic substructures that come before the integration of the id, ego and superego. For Kernberg, the “normal self” is a structure that integrates “good” and “bad” self representations, components invested with libido and aggression, to provide a realistic self concept (p.190-192). He argues that pathological narcissism reflects

libidinal investment in a pathologic grandiose self-structure which contains representations of the real self, the ideal self, and the ideal object. In this grandiose self, he says, “devalued or aggressively determined self and object representations are split off or dissociated, repressed or projected” (Kernberg, 1984, p.190). Kernberg explains that narcissists are grandiose, extremely self-centered and experience intense envy. They often feel empty and bored and lack the capacity for real sadness and mourning. Their relationships, while vital to their regulation of self-esteem, are shallow and exploitative, and they lack empathy (Kernberg, 1984).

Kohut (1971) posits that narcissism is a disorder of the self that results from an arrest at the infantile stage of self-objects due to a lack of maternal mirroring or the inability of the parent to be idealized. Self-objects are objects that are experienced as part of the self and therefore may be controlled. Kohut believes that all infants are originally grandiose and need to idealize their parents. He suggests that in normal development, when the environment is good enough, the exhibitionism and grandiosity of the archaic grandiose self is tamed and integrated into the ego of the adult personality and becomes ambition and purpose. Similarly, the idealized parent imago is integrated and provides tension regulation, leadership and super-ego ideals. If the environment is not good enough,

a fixation occurs, and these early rigid ideals of self and other cannot be modified. Kohut believes that this issue becomes clear in the treatment as the archaic grandiose self or the idealized parent imago is mobilized in the transference, leading to respectively a mirroring transference or an idealizing transference.

McDougall (1991) defines narcissism as a set of defenses erected to protect against extremely primitive libidinal goals and fantasies which are "attached to archaic objects of early infancy as well as part-objects of pregenitally conceived sexuality telescoped and confused with the individual's own self and body" (p.222). MacDougal states that narcissists either create a continual string of narcissistic object relations to stem the panic of separation, or disavow dependency needs altogether to defend against relationships for fear of fusion and loss of self. McDougall suggests that for women, "touching, looking, hearing and speaking" can all become dangerous because they are related to the archaic primal scene and envy and threaten to invade the fragile narcissistic self (p.242).

Grunberger (1989) posits that narcissism stems from the attempt to maintain a prenatal state of monadic bliss. He suggests that when the conditions of infancy are not right, the child clings to the primal maternal imago, personified by women, and cannot move to the Oedipal phase (p.188). He argues that the mother daughter relationship is particularly

frustrating for the little girl because the mother is only a substitute for a truly adequate sexual object, the father. He argues that female narcissism is an attempt to make up for maternal deficiency (Breen, 1993, p. 10).

Bach (1985) argues that narcissism is a disorder of the self, object relations, consciousness, cognition and affect that implies a deficit in the capacity to switch between objective self-awareness (being the center of the universe) and subjective self-awareness (being one among many). He describes two versions of narcissistic pathology: an over-inflated and a deflated type. The over-inflated type is classically grandiose while the deflated type is depressed and masochistic. Bach suggests that each has made a rigid either/or choice in their object relational world. The over-inflated type denies all need for another person in order to bolster the self, and the deflated type acquiesces completely, clinging to another person at the expense of feeling alive himself (Bach, 1985, 1994). Both suffer from emotional dysregulation, and both have problems of self-love and object-love stemming from problems of object-constancy and self-constancy. Bach (1994) suggests that the "object-submissive" type submits to anaclitic or narcissistic love objects and the classical egocentric type exhibits unique self-love. Bach suggests that the particular early disruptions in parenting that lead to these two types often co-exist and therefore the narcissist fluctuates between the

two extremes of self-awareness, able to experience himself either as subject or as object but not as both simultaneously. He argues that these shifts lead narcissists to fluctuate between object seeking and object fear in an attempt to maintain an equilibrium of self regard.

Describing the narcissistic experience, and the difficulty integrating different perspectives on the self, Bromberg (1998) states,

> The [narcissistic] individual tends not to feel himself at the center of his life. He is prevented from full involvement in living because he is stuck between 'the mirror and the mask'—a reflected appraisal of himself, or a disguised search for one, through which the self finds or seeks affirmation of its own significance. Living becomes a process of controlling the environment and other people from behind a mask (p. 75).

Types of narcissism

Only a grandiose, entitled form of narcissistic presentation is codified in the Diagnostic and Statistical Manual of Mental Disorders IV (DSM IV; 1994), but there is clinical and empirical evidence to suggest that there are different types of narcissistic pathology. The DSM IV defines Narcissistic Personality Disorder as "a pervasive pattern of grandiosity, need for admiration, and lack of

empathy that begins in early adulthood and is present in a variety of contexts" (p.658). This definition describes behaviors and attitudes present in one type of narcissist, but it is limited. The DSM IV does not attempt to describe an internal experience, but Cooper (1998) argues that, "the essential feature of NPD [Narcissistic Personality Disorder] is an invariable fragility of self-esteem regulation and an inability to sustain an adequate sense of self-worth" (pp.66-76). He explains that the grandiosity and self-centeredness described in the DSM IV are simply one possible defensive response to these struggles.

Reich (1960) was one of the first to write about different types of narcissistic presentation, and subsequently clinicians and theorists have continued to work to articulate the different experiences of narcissism (Bach, 1985; Bursten, 1973; Broucek, 1982; Cooper, 1998; Cooper & Ronningstam, 1992; Gabbard, 1989). Reich (1960) reiterated Jacobson's belief that self-esteem is "the expression of discrepancy or harmony between self-representation and the wishful concept of the self" (p. 216), and discusses two types of narcissists: one type seems to have no conflict about his exceedingly high opinion of himself, while the other struggles because he cannot live up to his unrealistic, infantile "inner-yardsticks." These types continue to be characterized in the literature, but they continue to be difficult to measure and are often missed

diagnostically.

Dickinson and Pincus (2003) investigated narcissistic issues in a non-clinical population to empirically study the spectrum of narcissistic presentations and validate the existence of a "vulnerable" narcissistic type as it is described in the clinical literature. They measured adult attachment styles, interpersonal styles and personality disorder criteria in a non-clinical young adult population and found two distinct groups of narcissistic personality styles that conformed to the grandiose and the vulnerable types. In this way, they empirically validated the concept of a vulnerable narcissistic personality, which is not found in the DSM IV. The authors suggest that vulnerable narcissists may often be misdiagnosed as Avoidant or Borderline personality disorder, their narcissism missed because of the DSM IV's focus on grandiosity.

Wink (1991) investigated current measures of narcissistic personality and found that a more covert form of narcissism does exist, but most scales used to measure narcissism do not include this form. Wink reviewed well-researched measures of narcissism and found that because they are based in the diagnostic criteria of the DSM, most scales only measure openly displayed grandeur and exhibitionism. Wink describes two scales that purport to measure the covert, hypersensitive narcissist, but these scales were so poorly correlated with other scales of

narcissism that there was a question of whether they were all measures of the same core pathology. Using other measures of pathology, including interviews with subjects' spouses, Wink was able to confirm that the scales were in fact a measure of narcissism, but it was an entirely different pole of the pathology from that measured in the other scales. He concludes that "narcissism in general, and covert narcissism in particular, are complex and multifaceted construct, and many of their characteristics are difficult to measure through self-reports or observer judgment" (p. 596).

The existence of these varied types/expressions of narcissistic disorders lead to different theories about the underlying pathology. Some theorists argue that narcissistic disorders exist on a continuum from the arrogant entitled to the depleted depressed (Gabbard, 1989), some see distinct subtypes (Bursten, 1973; Cooper, 1998), and some consider all patients with narcissistic pathlogy to have a range of experiences, and hold that the non-presenting parts of the spectrum become evident in treatment (Bach, 1985).

Gabbard (1989) considers the manifestation of narcissistic pathology on a continuum from the oblivious narcissist to the hypervigilant narcissist. He states that all narcissists struggle with self-esteem regulation, but they manage it in different ways. Oblivious narcissists are

arrogant, entitled and aggressive. They have no awareness of the reactions of other people and are self-absorbed. They must be the center of attention and seem to be impervious to the feelings of others. Hypervigilant narcissists, on the other hand, are inhibited, shy and self-effacing. They are highly sensitive to the reactions of others and tend to direct attention away from themselves. Their feelings are easily hurt and they are prone to feelings of shame and humiliation (pp. 528-529). Gabbard believes that many narcissists fall somewhere in the middle of the continuum and posits that some of the theoretical disagreements about the disorder stem from focusing on one side of the continuum or the other rather than seeing the full range of possible pathology.

Bursten (1973) argues that individuals with narcissistic personalities constantly work to maintain or restore the self-esteem that is experienced in the reunion of a grandiose self with an omnipotent object representation. They struggle with this, he argues, because they have all been "disappointed and betrayed by someone who was not powerful enough or ready enough to given them what they needed" (p.292). Bursten suggests four narcissistic character types: the craving, the paranoid, the manipulative and the phallic. The craving type needs other people to support them. They are excessively demanding and clinging, due to an inability to really depend on others, and they

frequently experience disappointment. When not fed by others, they do not have the energy to function. The paranoid type shows excessive self-importance and a tendency to blame others for their problems. They are hypersensitive, rigid, suspicious, jealous, and frequently argumentative. These people are not delusional, but tend towards ascribing negative motives to others. The manipulative type consists of narcissists who consciously deceive and attempt to influence others to get what they want. They feel pleasure when the manipulation succeeds. These people are at times categorized as anti-social or sociopathic, but Burtsen believes it is important to differentiate them as a group because those diagnoses rely heavily on behaviors and the effect of behaviors rather than on the individual's motivation to manipulate.

Cooper (1998) characterizes narcissistic pathology as marked by damaged capacity for emotional ties to others, damaged capacity for sustained pleasure in one's own activities, damaged capacities for mourning and sadness and inner feelings of deadness and boredom. He argues that there are two distinct subtypes of the disorder, the overt narcissist and the covert narcissist. He outlines the disordered experience in terms of self-concept, interpersonal relations, social adaptation, morality, love and sexuality and cognitive style, and for each of the two types he shows how each area is affected by a narcissistic

impairment in self-representation and self-esteem regulation. According to Cooper, overt narcissists are grandiose, arrogant and entitled. They are socially charming and have many shallow relationships characterized by the need for tribute. They are frequently professionally successful and live by a personal, idiosyncratic morality. Overt narcissists tend to be promiscuous and to have uninhibited sexual lives regardless of their marital status. Their cognitive style is decisive and opinionated, and they are often knowledgeable about their interests, but they have an egocentric perception of reality. Covert narcissists believe they are inferior and feel morose and self-doubting. They tend towards shame and humiliation and present as inhibited and shy. They are unable to trust or depend on other people. They are professionally uncommitted and tend to falter in their work. They are unable to sustain love relationships and they have difficulty seeing their partners as separate individuals. Their morality depends on what serves them at the moment. Covert narcissists tend to have a vague cognitive style and only shallow knowledge of events, and they tend to change reality when their self-esteem is threatened (p.62-63). Cooper argues that it is crucial for treatment to understand both types of the disorder as having issues of impaired empathy and excessive envy.

Bach (1985) also argues that there are two types of

narcissists which he terms the overinflated narcissist and the deflated narcissistic. The over-inflated type is grandiose, hypomanic and sadistic, and consciously feels that he is the center of the universe. The deflated narcissist is depressed, clinging and masochistic and consciously feels inferior to others. The overinflated type tends to form mirroring transferences, to reflect their own grandiose images. The deflated type tends to form idealizing transferences, as a way to receive the positive other. Bach argues that the pathology that is expressed is just one side of the coin and believes that in an analysis the non-dominant experience will be uncovered and the two parts of the self can begin to be integrated.

Development of narcissism

There are multiple theories of narcissistic development, which are, not surprisingly, aligned with the range of views on the definition and manifestation of narcissistic pathology. The core area of disagreement concerns the timing and quality of the disruption in development.

Kernberg (1984) posits that narcissistic pathology occurs in children with intense oral aggression in the period after rapprochement, when the ego boundaries have already become stable. These children's aggression may be caused by a particularly strong, innate aggressive drive, a

constitutional lack of anxiety tolerance in regard to aggressive impulses, and/or severe frustration in the early years of life. Parents are often exploitative and cold, and although they acknowledge separation they use the child for self-aggrandizement. Kernberg argues that at the stage of separation, the child's oral aggression and the parents' inability to respond appropriately become too threatening and, "as defense against an intolerable reality in the interpersonal realm, with concomitant devaluation and destruction of object images as well as of external objects" (Kernberg, 1985, p.231), the ideal self, the ideal object, and the real self are condensed and fused. This self-structure protects the narcissist against the denigrated self and the destroyed objects.

Kohut (1971) argues that narcissistic fixations occur if there are severe narcissistic traumas for a child, for example a lack of mirroring in early practicing, or if the parent is traumatically disappointing by not being able to be idealized during rapprochement. If these traumas occur, then the grandiose self and the idealized parent imago cannot be modified or integrated and the structures remain intact in their archaic, infantile forms. Lacking mirroring, the child becomes more grandiose in order to combat the narcissistic trauma. Without opportunities for parental idealization, the child feels a sense of emptiness. Kohut argues that there is no innate aggression in

narcissism, but that rage comes out of narcissistic disruptions and injuries.

Pauline Kernberg (1998) agrees that narcissistic pathology is the result of problems in the separation-individuation process, but explains that there is a range of struggles in this phase. In each case, she argues, "the child can function and be supported only as long as he or she molds to the parent's expectation. Although the child's individuation is facilitated, no sense of separateness is acceptable" (p.116). However, she explains, particular fixations are related to arrests in different parts of the process. Some may be arrests in the early practicing stage, when the child has very little sense of the external world, and others may occur during rapprochement, if a parent does not respond sufficiently to a child's dependency needs.

Bach (1985) suggests that narcissistic pathology stems from mismatches in the early parent-child relationship and also stresses a range of possible conflicts. He argues that all infants have a primary identification with the mother of symbiosis, merger and bliss, but then, in order to develop reflective self-awareness, they need the mother of separation who is able to mirror them and reflect their experience. A mother who is unavailable for refueling, forces a child to sustain himself leading to an over-cathected self-awareness. At the other extreme, if a mother imposes her own initiative on the child, the child feels

that forces outside himself determine his existence and is left with an under-cathected self-awareness. Bach also describes a failure in mirroring that leads the child to be unable to develop reflective self-awareness and a sense of self as a thinker and doer in relation to an object.

Fonagy (1999) details the nuanced mirroring that is crucial in the development of symbolic representation and affect regulation. He explains that the mother must reflect the infant's affect in such a way that a representation of that affect may be internalized. This reflection must be contingent – accurate – and marked – clearly the infant's and not the mother's. The mother's mirroring of affect must be close enough to the infant's affective experience to be recognized and far enough from it to tolerated. If this fails, the infant feels either overwhelmed by the mother or abandoned.

Some argue that the divergent theories of development are based in experiences with different types of narcissistic presentations (Bursten, 1973; Broucek, 1982). Blatt (1983) explains two types of developmental traumas: anaclitic traumas that involve the threat of the loss of the mother or the threat of the loss of her love, and introjective traumas that are threats of the loss of super-ego approval and the threat of castration. Psychopathology in the anaclitic realm involves preoccupation with

interpersonal relationships to the neglect of the development of the self; the self ends up determined only through relationships to others. Psychopathology in the introjective line involves exaggerated concerns about self-definition to the exclusion of establishing interpersonal relationships. Considering the different types of narcissistic pathology discussed above, it seems possible that different presentations may be based in different traumas.

Bursten (1973), for example, attempts to explain some of the specific ways that parents are unable to facilitate separation and the resulting different types of narcissism. He suggests that the craving type struggles with symbiosis; they tend to have weak fathers and mothers who value them only as babies. Paranoid personalities reflect issues of negativism during separation and frequently the family dynamic is sado-masochistic. The manipulative personality is more secure in separation than either the craving or the paranoid, but there is a focus on public presentation rather than internal experience and difficulty with fully individuating. The phallic narcissistic type has best achieved separation-individuation, but still regresses to the need for symbiosis at times. The mother's of phallic types (in Bursten's work he is only considering sons) have an ambivalent relationship to their children's independence. They appear to value masculine power very highly and push

their children to be manly and separate, but they cannot tolerate the independence and so undermine achievements. Bursten (1973) explains that the timing and quality of the parental struggle determines not only the narcissistic expression, but the integration and stability of the self-structure.

Level of organization

The specific disruption in the development of self-structure in narcissistic characters also determines level of organization. Kernberg (1984) outlines three structural organizations, which correspond to neurotic, borderline and psychotic, personality organizations. Each level of organization details a self-structure, primary defenses and predominant object relations. People at the neurotic level of organization have integrated identities, use primarily high-level defenses and have no particular pathology of internalized object relations. They may have overly harsh super-egos, but these too are well integrated. People with borderline personality structures maintain good reality testing, but they have non-specific manifestations of ego weakness. They experience identity diffusion, have low affect and anxiety tolerance, and experience severe fluctuations of self-esteem. People at the borderline level rely heavily on more primitive defenses like splitting and their internalized representation of both self and other are

distorted. Sadistic forerunners of the super-ego predominate in their self-structure. At the psychotic level people experience poor reality testing and use primitive defenses which prevent them from being able to relate to others.

Narcissistic pathology is difficult to categorize, and narcissistic issues manifest differently depending on the level of organization. Bursten (1973) and Cooper (1986) argue that narcissists tend to have a stronger sense of self and less fragmentation than people organized at a borderline level, but Kernberg (1984) suggests that many narcissistic characters are organized at a borderline level because their self-structure is not integrated and their internalized object relations are delimited.

These different views of the level of organization achieved by individuals with narcissistic pathology reflect different developmental positions. Kohut (1986) locates narcissistic disorders in a failure of early mirroring whereas Otto Kernberg (1984) locates narcissism later in development, after separation has largely occurred, when the self is more developed. He argues that earlier disruptions lead to borderline conditions. Pauline Kernberg (1998), on the other hand, suggests that narcissistic pathology occurs when there are parental failures during separation. Westen (1990) uses empirical studies to argue that adult pathology

cannot be located in a specific phase of early childhood, but rather has multiple determinants from the earliest biological factors to ongoing environmental and dynamic interactions.

The role of gender

As briefly outlined above, theories of narcissistic development disagree as to whether they stress the primacy of Oedipal or preoedipal conflicts, the role of the infant's aggression, the role of multiple selves, the role of the mother, and whether the pathology stems from a fixation at or regression to, a normal stage of development (primary narcissism) or constitutes a separate line of development. However, in each area of narcissistic development gender may play a role. Early theorists often discussed the difference in etiology of narcissism for males and females, focusing on the difference in core conflicts and psychosexual stages, but most current writers do not directly discuss the role of gender in their formulations of narcissism.

The experience of difference

In *On Narcissism*, Freud argues that women are more narcissistic than men because men can manage their narcissistic injury through identification with the powerful father while women must remain injured until can have a child and thereby incorporate the penis.

> Complete object-love of the attachment type is, properly speaking, characteristic of the male. It displays the marked sexual overvaluation which is doubtless derived from the child's original narcissism and thus corresponds to a transference of that narcissism to the sexual object…. A different course is followed in the type of female most frequently met with…. Women… develop a certain self-contentment which compensates them for the social restrictions that are imposed upon them in their choice of object. Strictly speaking, it is only themselves these women love with an intensity comparable to that of a man's love for them. Nor does their need lie in the direction of loving, but of being loved; and the man who fulfills this condition is the one who finds favour with them. (Freud, 1986, p.31)

Freud concludes that some women are able to internalize a masculine ideal that allows them to develop object love more fully, but that many women only overcome their secondary narcissism and develop true object-love with the birth of a child.

Jacobson (1990 [1937]) posits that the gendered resolution of castration anxiety leads to a female narcissism that is object related and a male narcissism that takes the place of object relations. Jacobson suggests that

both little girls and little boys experience castration anxiety, but the girl's occurs during the preoedipal relation to the mother and takes longer to heal. She argues that for women the narcissistic wound of castration is healed through displacement of libido to other parts of the body or to the body as a whole. The success of her acceptance of castration is determined by the successful development of a love relationship with the father, but even this resolution is not fully satisfying. Jacobson suggests that "the narcissistic cathexis had been displaced from the woman's own genital to the love object… the castration fear could be regressively equated with the loss of love" (p.192). She acknowledges that ideas about femininity, and women themselves, are changing, and suggests that this construction may eventually be less necessary, but at the time she is writing — 1937 — she concludes,

> thus if the girl adopts the female position, the castration wishes directed at the father are not warded off with the aid of the phallic partial identification with the father in the superego, but by an elaboration of object relationship in which the possession of the father as love object-ensured by the reception of the penis in the sexual act-compensates her for giving up the genital…. From then on the female anxiety of conscience becomes to a certain extent a secondary "social anxiety;" above all the opinions and judgments

> of the love object become decisive and—like his penis—can always be taken from him again (Jacobson 1990 [1937], p.195).

The women Jacobson discusses in this paper might now be considered more borderline, but Jacobson frames their pathology as one of self-esteem and narcissistic vulnerability and seems to be describing a more anaclitic, feminine narcissism and a failure of idealization. In the situation where a parent, in this case a father, cannot tolerate idealization, the girl child's love relationship with that father may be impaired and she may not be able to resolve her bodily anxieties. She may then need to continuously use the object to bolster her self and may constantly struggle to prevent further injury and maintain self-esteem.

Blatt (1983) argues that these anaclitic issues are more prevalent in females while introjective issues are more prevalent in men. Blatt attributes some of this gendered division to societal values. He (1983) states:

> disorders of anaclitic configuration occur with greater frequency in women. Western society appears to place more manifest emphasis on the need for self-definition in men, and a greater emphasis for women on the capacity for relatedness-for giving care, affection and love. Developmental disruptions, therefore, are often

> expressed in males and females along predominant tasks defined by cultural expectations (p.247).

In addition to positing differences in expectations, Blatt argues that anaclitic trauma, danger involving separation from the love object, is core to female sexuality, whereas introjective trauma, danger involving the loss of superego approval, is core to male sexuality. Men end up feeling guilty and filled with self-reproach because of castration anxiety. Women, he posits, end up feeling helpless because of loss of the mother's love.

The mother of separation

Winnicott (1989 [1968]) differentiates between object relating, the ability to cathect to an object and thereby alter oneself, and object use, the ability to cathect to an object whom you accept as having an individual existence in shared reality. To develop the capacity to use an object, the subject needs to be able to destroy the object and have it survive. The object can then be understood as external and outside of omnipotent control; it can be destroyed over and over in fantasy. Winnicott argues that there is no anger in the original destruction, but aggression is part of the experience of constructing a self and an external reality that can be shared by others. Benjamin (1998) explains that, "the original dialogue with an outside other

is the basis for the internal process of thinking and representing. The mother's dialogic ability stimulates the child's recognition of her subjectivity; as she represents and reflects back the child's own subjectivity, she initiates symbolic capacities" (p.53).

Narcissistic disorders are frequently understood to involve a disruption in this process of separation and an inability to experience this otherness. Jacobson (1954) argues that prolonged over-gratification in the mother-child unit can delay the child's capacity to establish firm boundaries between the self and the objects. Bursten (1973) states "mothers of narcissistic patients, in varying degrees, have difficulty letting their children separate" (p.296). Rosenfeld (1964, 1971) explains that narcissistic disorders are precipitated by the inability to tolerate separation because of the loss of omnipotence and the dependency and envy that that loss evokes.

According to Bach (1985), "A primary identification with the mother of symbiosis seems necessary for the cathexis of inner reality, for the subjective self awareness and self-absorption, and for the experience of merger and bliss" (p. 65). A later "identification with the mother of separation seems necessary for the capacity to be alone, for objective self-awareness and for the ability to love as two autonomous objects rather than as part-objects of a dual unity" (Bach, 1985; p. 65). Identification with the mother

of separation may be particularly complicated for girls because mothers tend not to push separation as forcefully on girls, and because girls do not shift their primary identifications to their fathers.

After the early attachment relationship with the mother, the child must separate. Boys must switch their parental attachment for identification and girls must switch their parental attachment for affection. The struggle between separation and continued love and its attendant traumas/conflicts around the realization of difference is expressed and resolved differently for male and female children.

Chodorow (1978) describes at length how women's primary mother role makes for differences in the preoedipal and Oedipal development of male and female children. She analyzes case studies by gender and finds that mothers have more trouble separating from their daughters than from their sons. "The mother does not recognize or denies the existence of the daughter as a separate person, and the daughter herself then comes not to recognize herself as a separate person…. [These daughters] act as extensions of their mothers, [acting] out aggression which their mothers feel but do not allow themselves to recognize and act on" (p.103). Chodorow explains that boys are also affected by mothers who have difficulty separating, but because they are innately different they are seen as other. These boys tend

to react to their mothers wishes as if they were objects, gratifying the mother, but they experience themselves as separate and other. Chodorow argues that the complexities of separation continue for girls well beyond the Oedipal stage. A girl's relational ambivalence towards her mother, she says, persists through the Oedipal stage, because a girl child cannot shift the early intense love of her mother entirely onto her father; even if she is able to make a sexual shift, she remains emotionally triangulated.

Mitchell (1974) explains the separation dilemna for the girl child from child's perspective and characterizes even the early mother daughter relationship as one of intense ambivalence. She explains, "the very primacy and intensity of this relationship makes it liable to contain hate as well as love -- the girl, unlike the boy, cannot make a separation of these emotions and transfer the hatred to a rivalrous father, because she must too soon come to take this same father as her love-object" (p.57).

Haaken (1983) reviews the literature on gender and individuation and suggests that boys are pushed by the mother to separate while girls are more apt to remain overly-connected to their mothers. "The sex of the child carries important meaning for the parent who identifies more readily with the same sex offspring. Mothers identify more closely with their daughters than with their sons and emphasize their sense of sameness by imitating them more.

From their earliest infancy, male children may be pushed to develop a premature sense of separateness from the mother" (p.318). Haaken argues that the push to separate leads to more narcissistic pathology. This theory is similar to Kernberg's theory of parental failure during rapprochement leading to grandiosity, but Kernberg adds to the parental reality the infant's intense, innate aggression, which may also be a more male attribute. Haaken does not see maternal over-connection as a narcissistic issue, however. She argues that the experience of being used as a maternal extension leads to borderline pathology, but Kohut argues that excessive mirroring can also lead to narcissism. In this way, Kohut's etiological construction of narcissism seems more in line with female development.

Fogel (2005), referencing current theories of gender development, notes that ideas of masculinity and femininity are crucial in many areas of experience but are not simply tied to anatomical sex. He argues,

> That masculine and feminine are a gender polarity existing in every individual, regardless of anatomical sex or core gender identity. A strong and stable gender identity, be it as a man or a woman, requires developmental evolution and the integration of a meaning-generating dialectical space that contains this polarity (p. 1141).

This view of maleness and femaleness suggests a need for both boys and girls to develop an integrated otherness with the mother of separation to allow for space for both masculine and feminine identifications.

McDougall (1985) argues that “narcissistic pathology has its roots… in the inevitable trauma of otherness and the obligation to assume separate identity” (p.221). She explains that for the infant, the mother is a magical extension of the infant, a sheltering force protecting the infant against the death instinct. At the same time, there are moments of separation when the infant begins to have independent psychic experiences. If a mother shows excessive or insufficient investment in her baby and its body, the baby risks being overwhelmed by the reality of difference and the inevitability of death. To protect herself, the baby will mobilize narcissistic defenses that may become entrenched and be protected at the expense of healthy object relations.

Cooper (1988), citing Edmund Bergler’s theory, argues that narcissism and masochistic phenomena are intrinsically linked. Bergler, Cooper explains, posits that an infant, “faced with unavoidable frustration, the danger of aggression against parents, who are also needed and loved, the pain of self-directed aggression… learns to extract pleasure from displeasure for the sake of the illusion of continuing, total, omnipotent control both of himself and of

the differentiating object" (p. 122). Cooper (1988) posits that even in normal development pain and frustration are necessary parts of the separation process. The infant will experience this suffering as a narcissistic injury and humiliation because it threatens her omnipotent control and forces her to experience helplessness. In an attempt to restore self-esteem and reassert control the infant will distort the nature of her experience and make the suffering ego-syntonic. In situations of more extreme suffering, with greater pain and less reward, the infant may "attempt to salvage pleasure by equating the familiar with the pleasurable" (Cooper, 1988, p. 127). If the infant experiences excessive early narcissistic humiliation for either internal or external reasons, "being disappointed, or refused, becomes the *preferred* mode of narcissistic assertion to the extent that narcissistic and masochistic distortions dominate the character" (p. 128). The infant can no longer be disappointed because disappointment is pleasurable. The infant has found a way to maintain the fantasy of control over a damaging, rejecting, cruel mother. Cooper (1988) explains that these people exhibit a "deadened capacity to feel, muted pleasure, a hypersensitive self-esteem alternating between grandiosity and humiliation, an inability to sustain or derive pleasure from relationships or work, a constant sense of envy, an unshakable conviction of being wronged and deprived by those who are supposed to

care for [her], and an infinite capacity for provocation" (pp. 128-129).

Gendered narcissistic experience

Women and hidden power

In Psychoanalysis and Feminism, Mitchell reminds her readers of the female character, Echo, in the myth of Narcissus. As punishment for speaking too much, Echo is condemned "never to speak in her own right"; she can only speak in response to another. She falls in love with Narcissus who is so absorbed with himself that he cannot speak to her and she pines away until she dies. Echo is not explicitly part of most analytic discussions of narcissism, but it is interesting to consider her role in the myth and the possibility that she too represents some part of the pathological character structure. A narcissistic woman may hide her voice, her power, for fear of punishment, but needing that power and knowing she possesses it, she seeks to regain it through her male love object.

Benjamin (1998) describes this renouncing of power as a response to the mother's control. She argues that, "the maternal object is split: femininity as absorption, accommodation and receptivity, is constituted as the antidote opposing the phallic mother's control" (p.57). This position acknowledges feminine power, but it displaces that power onto the father and fulfills cultural

expectations of femininity.

Dimen (1991) explains that in our culture men are supposed to desire while women are supposed to be desired. She argues, “this dualism between wanting and being wanted intersects not only with the contrast masculine/feminine but that between subject and object” (p. 343). As adults women must also be subjects in order to succeed so a compromise is necessary in femininity, but there is a primary experience of being an object and a need to be desired.

In “*Womanliness as a Masquerade*,” Joan Riviere describes a subset of women who hide a deep wish to be masculine. In their version of the feminine compromise, she says that these women “may put on a mask of womanliness to avert anxiety and retribution feared from men” (Riviere, 1991 [1929], p. 91). These women are not overtly homosexual, but not fully heterosexual. They are highly intellectual, ambitious women who are often successful in work, but use their femininity defensively and therefore cannot fully express themselves or obtain full pleasure in relationships.

Riviere describes these women as developing a masculine identity that they use in the service of protecting their mothers. She explains that their development has been complicated by intense sadism due to frustration during sucking or weaning. At this stage of development, both parents are rivals for the girl, but the girl’s intense

hatred of the mother leaves her with an overwhelming fear of destroying her. Riviere, following Klein, argues that a girl in this predicament attempts to resolve the rivalry without destroying the mother by identifying with the father. She "then uses the masculinity she thus obtains by putting it at the service of the mother. She becomes the father and takes his place, so she can restore him to the mother" (Riviere, 1991 [1929], p.98). The girl feels superior to the mother because she possesses masculinity, but she is self-sacrificing and devoted in an attempt to restore what she has taken and make good. In response to this restitution, this goodness, the girl child needs recognition and gratification from the mother. She has triumphed over the mother, but the triumph is secret (p.99).

These women need supremacy in order to feel safe; they must continue to secretly triumph or they become enraged and depressed. Riviere suggests that for one analysand, "womanliness… could be assumed to hide possession of masculinity and to avert the reprisals expected if she was found to possess it" (1991 [1929], p.94). Riviere also describes women who are compulsively "guiltless and innocent" and who minimize their competencies to avoid threatening men and being discovered. Another solution to the need for recognition is sexual. In relation to men, these women enjoy sex because it brings gratification through "reassurance and restitution of something lost, and

not ultimately pure enjoyment. The man's love [gives the woman] self esteem" (Riviere, 1991 [1929], p.95).

While Riviere's paper is about homosexual versus heterosexual development, it is strikingly relevant to the use of the body and the more covert grandiosity of a subset of narcissistic women described by my subjects. While Riviere attributes the problematic resolution of rivalry to an intense sadism on the part of the girl, it seems that resolving that rivalry with a narcissistic mother or a mother who was unable to tolerate separation could also lead to a similar attempt to placate the mother through identification with the father and incorporation of his masculinity. Riviere's suggestion that the group of women she describes use "womanliness," and specifically the female body, to ward off narcissistic injury and gain power may be similar to the use of the body as object in female narcissism. Riviere also describes these women as feeling they possess the phallus, but hiding their possession so as not to be castrated and, at the same time, needing to be recognized for their possession. Perhaps women's more martyring grandiosity is a sense of phallic power that must be hidden under an acceptable feminine experience, an excessively care-taking model, so as not to be attacked and destroyed.

Montrelay (1993) describing the resolution of castration anxiety states:

> one can play on the absence of the penis through silence just as well as through a resounding vanity. One can make it the model of the erotic, mystical, and neurotic experiences. The anorexic refusal of food is a good example of the desire to reduce and to dissolve her own flesh, to take her own body as a cipher. Masochism also mimes the lack, through passivity, impotence and doing nothing ("ne rien faire")…. In order to produce this nothing, the woman uses her own body as a disguise (155-156).

These theorists suggest that in response to castration anxiety and the power of the mother, women may develop a form of femininity in which they hide the omnipotence they feel and perform passivity.

The body

If narcissism is a disturbance in development related to a faulty resolution of the experience of otherness and separation, then it seems likely that the literal embodiment of that otherness, the physical, gendered body, would be involved in that resolution. Diverse theorists have noted narcissistic issues' implications for the body. They focus particular on hypochondriasis as a narcissistic symptom. Reich (1960) explains that, "self-consciousness* and

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*Reich (1960) defines self consciousness as "an accentuated

hypochondriacal anxiety both are typical symptoms in persons with narcissistic pathology. They represent, so to speak, the reverse side of the narcissistic self-inflation" (p. 218-219). Bach (1985) states that patients with narcissistic disorders frequently have a history of "head banging, skin masochism, vestibular disturbances or hypochondriasis as restitutive attempts to recathect the self-boundaries" (p. 18). There is also a sense that the body is crucial in the process of separation, and so even a disturbed separation involves the body. Cooper (1988) argues that skin sensations, even painful sensations, are a way of differentiating oneself from an other. McDougall (1991) posits that the earliest experiences of the difference, the self non-self distinction, is the difference between two bodies. Given the gendered experience of bodily difference, perhaps female narcissists use their bodies in the service of their narcissism in specifically gendered ways. Eating disorders, Somatization disorders and plastic surgery are more prevalent in women than in men and it seems possible that in some cases these may be defenses against narcissistic injuries and/or attempts at omnipotence.

Most theoretical constructions of narcissism contain some implication for sexual manifestation as well. Kernberg (1975) refers to a "polymorphous, perverse sexuality," Bach

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state of awareness of the own self and also indicates the assumption that the same exaggerated amount of attention is paid to one's person by others" (p. 229).

(1984) to sado-masochistic object relations and Reich (1953) to women's use of sexual intercourse in the service of grandiosity. Mitchell (1974) suggests women become the passive object rather than the active subject. However, along with more sexual "dyadic" manifestations of narcissistic pathology there appears also to be a more basic level of the use of the body for narcissistic gratification.

Theorists who argue that girls experience castration anxiety suggest a number of different resolutions for women's early narcissistic injury involving the body. The body itself can become a narcissistic tool to be perfected; the body can become an object for others, and the body can be a stage to play out hyper-femininity and/or control.

Kohut suggests that, for women, the entire body becomes a source of narcissistic inflation to make up for the lack of the phallus. He states:

> after psychological separateness has taken place the child needs the gleam in the mother's eye in order to maintain narcissistic libidinal suffusion which now concerns, in their sequence, the leading functions and activities of the various maturational phases. We speak thus of anal, of urethral, and of phallic exhibitionism, noting that in the girl the exhibitionism of the urethral-phallic phase is soon replaced by exhibitionism concerning her total appearance and by an interrelated exhibitionistic

> emphasis on morality and drive control (Kohut, 1986, p.69).

If drive control is exerted on the body then women may exhibit excessive control of intake as in eating disorders. It is also possible that women's desire for total control of their bodies is an attempt to return to an infantile state of omnipotence.

Mitchell argues that women use their whole bodies to compensate for their lack of a penis. She argues that a woman "caught out… at the height of [her] narcissistic phase with the enforced recognition of the inferiority of the clitoris… compensates for the great hurt by making her whole body into a proud substitute" (Mitchell, 1974, p.116). Mitchell suggests that this may lead to great vanity. If women use their bodies as substitutes for the phallus, or more generally as tools of power, then they may experience their bodies as objects and develop a fetishism of the body that could be pathological.

Reich (1953) argues women suffer from regressions to infantile omnipotence to combat the trauma of the differences in the sexes. Following Freud, she uses the term narcissism to refer to conditions where one's own body is treated like a love object, the differentiation between ego and object is diffuse, and thus primary identifications take the place of object love. Narcissism can also develop

when problems of self esteem regulation predominate because infantile omnipotence was not resolved or was regressively revived. She asserts that, for women, “the need for narcissistic inflation arises from striving to overcome threats to one’s bodily intactness” (Reich, 1960, p. 219). Some women’s narcissistic inflation makes them sexually unavailable and frigid, while other women gain “grandiose masculinity… through ecstatic intercourse” (Reich, 1953, p. 27).

Lieberman (2000) further complicates the question by suggesting that some that narcissistic women appear to be fulfilling a sexualized feminine ideal, but their goal is actually more primitive. She states, “although they report they’re aimed at satisfying the contemporary males desire for a thin woman, they… are generally sexually anesthetic and uninterested in sex. They do seek with men the holding and cuddling, and visual attention that shores up the sense of the body boundary” (p.153).

Stoller (1976) posits a two-stage gender development: primary femininity involves outward behaviors and secondary femininity which develops through the Oedipal conflict and resolution involves depth and feeling and fills in the internal world of the feminine behaviors. Following an Oedipal theory of narcissistic development then, it is possible that narcissistic women have all the outward trappings of femininity, but lack the internal experience.

Supporting the idea of an external femininity that needs shoring up are cases of women who use the "trappings" to feel feminine. In *Ladies Of Fashion: Pleasure, Perversion Or Paraphilia*, Richards (1996) discusses the dominant role that women's clothing has played in psychology and the various meanings attributed to fashion. In this article, she describes two patients who use clothes to shore up their sense of femaleness. Richards describes one women for whom

> clothing and make-up were disguises for her sense of herself as ugly and worthless…. She seemed to be searching for another body. She was, I now think in retrospect, expressing with her clothes the restless disappointment with her own body and her wish to change her body back and forth, now thinner and more childish, now fuller and more womanly (p.341).

Richards also discusses a patient who attempts to manage feelings of loss of femininity through her clothing.

> Mary, a very successful career woman patient reports: 'I went to the doctor yesterday. He told me I had started menopause. Not what I wanted to hear. Why does this have to happen now? Anyway, my first thought was to go and spend a thousand dollars on clothes (p. 342).

These women manage their concerns about femininity through consumption, spending and clothing, costuming a feminine self.

Treatment

With the role of gender and the different forms of narcissistic presentation in mind, I now turn to the issue of treatment. I will give only a brief overview of some theories and challenges of analytic treatment with narcissistic characters. I will discuss only analytic and analytically-informed work because that is my theoretical and clinical interest, and because it is most relevant to the material of this investigation. I am interested in the different experiences of treatment with patients with different types of narcissistic pathology, and, especially in the role of narcissistic rage (either innate to the patients or as a response to treatment) in the work with more covertly narcissistic characters. There is no discussion of the role of gender for the analyst or the patient in the literature of analytic treatment with patients with narcissistic pathology.

There are a number of difficulties that vex treatment with narcissistic characters ranging from identifying the pathology to their capacity for developing a workable transference. Freud believed that narcissistic development was at the expense of object relations, and therefore patients with too much narcissism would not be able to develop a transference relationship and were thus

unanalyzable (Ellman, 1991). But empirical and clinical data suggest that great gains can be made with patients with narcissistic pathology in long-term treatment (Adler, 1986; Bateman & Fonagy, 2000; Higgitt & Fonagy, 1992; Leuzinger-Bohleber & Target, 2002; Kernberg, 1986; Kohut & Wolf, 1986; Rothstein, 1984). Kernberg (1986) describes the current view of treatment by saying, "many experienced clinicians consider these narcissistic personalities as unlikely candidates for analysis, but at the same time as hopeless candidates for any method of treatment other than psychoanalysis" (p. 227). In short, psychoanalysis is the only treatment that might help patients with narcissistic disorders.

The forms of transference and the goals and methods of treatment are still debated. Kernberg (1986) describes the primary task of treatment with patients with severe narcissistic pathology as the analysis of the pathological grandiose self. He believes that the therapist should take a neutral, interpretive stance throughout the treatment.

Kohut and Wolf (1986) suggest that, "since the central pathology in the narcissistic behavior and personality disorders is the defective or weakened self, the goal of therapy is the rehabilitation of this structure" (p. 192). This is a long and difficult process, and in it the therapist must serve many functions including interpreting therapist, listening other, selfobject, and container for

the dissociated self.

Kohut and Wolf (1986) describe the experience of a fragmenting self for a subset of narcissistic pathology and argue that this disintegration of the self occurs in those people who have not had an integrating other in childhood. Winnicott argues the defense of disintegration functions to alleviate the anxiety of falling to pieces which is actually "the fear of a breakdown that has already been experienced" (1989 [1963], p. 90). He further posits that the fear arises because the original trauma has never fully been experienced and therefore cannot be moved into the past. Winnicott argues that the treatment can be the containing, holding environment where the analyst becomes the mother and allows these early traumas to be experienced for the first time.

Bach (1994) explains "that certain patients have never constructed a world at all, or have deconstructed or lost the meaning of their worlds" (p. 162). He argues that the analyst must help these patients construct or reconstruct the world by becoming the kind of listener that can give meaning to that world. The goal becomes to help the patient integrate and "to feel like one self while being many" (Bromberg, 1998, p. 186). Lieberman (2000) suggests that, "narcissistic patients make use of the therapist as a spectator…the therapist's focus on their bodies enables them to supplement its insufficient cathexis" (p. x).

Many theorists suggest that with patients with narcissistic pathology, the role and experience of the analyst changes over the course of the analysis. Rothstein (1984) posits that in the beginning of the analysis, the task of the analysts is to tolerate and even enjoy the patient's narcissistic defenses, and to allow the patient to experience and develop the narcissistic transference fantasies. It is not, he argues, until the mid-phase of analytic work that the defensive function of these narcissistic investments is analyzed. Bromberg (1998) suggests that the early stage of treatment is "a stage of maximum empathy and minimum confrontation, but with sufficient anxiety to get most of the core issues out on the table" (p. 93).

LaFarge (1998) argues that the treatment is about interpreting the primitive object relations. She also outlines three stages of treatment and states that often in the beginning of treatment the narcissistic patient develops a stable transference configuration that makes him or her inaccessible to the analyst. Once this occurs, the analyst must attempt to understand

> the specific fantasy structure underlying the patient's rigid narcissistic object relations and to interpret both the many defensive functions that the structure serves and the highly condensed primitive object relations that emerge as defensive functions are

interpreted (p.179).

These interpretations lead into the mid-phase of treatment in which the analysis is dominated by aggressive fantasies. These fantasies cycle through being experienced as paranoid rage, violent wishes against hated objects and more realistic anger at whole objects (p.183). In this phase the rage is analyzed so that the patient can develop more integrated whole objects. In the late stage of treatment the patient has an awareness of the analyst as a more complex figure. Patients in this stage often experience guilt and regret, and it is in this stage that a more traditional transference neurosis develops. When these more integrated representations of self and object can be maintained even in situations of stress or loss, termination is possible.

Transference and countertransference

Freud suggested that narcissists were not able to form a normal transference and did not have the libidinal investment available for the analyst to commit to an analysis, but analysts no longer understand patients with narcissistic disorders in this way (LaFarge, 1998). Rothstein (1984) explains that a narcissistic patient's "analyzability" depends on the level of integration of the narcissistic defenses. He argues that those who are analyzable "will have an analytic experience characterized,

in part, by mourning of illusions of narcissistic perfection for the self-representation-as-agent and by their ego's progressive relinquishment of its narcissistic pursuits" (p.114). However the specific nature of the disorder is framed, it is now widely believed that patients with narcissistic pathology develop transferences that are specific to the disorder and that understanding the transference countertransference dynamic with these patients helps to illuminate the pathology itself.

Kohut (1971) posits that there are two possible transference reactions for the narcissistic patient: an idealizing transference in which the idealized parent imago is mobilized and a mirroring transference in which the archaic grandiose self is mobilized. Kohut suggests that idealization of the parent is necessary to ward off the danger of early life. When the process is disrupted, the child does not internalize the idealized parent but continues to assign perfection to an idealized selfobject. The child is then forced to be in continuous union and merger with the object because the object contains all of the power and the bliss. In treatment, this archaic omnipotent object may be reactivated and the therapist may become the idealized selfobject. Kohut states that in an idealizing transference, "the analysand becomes addicted to the analyst or to the analytic procedure" (p. 46).

LaFarge (1998) explains that the object relations

theorists consider what used to be seen as a lack of transference as a specific narcissistic transference that represents the activation of early object relations. She explains,

> the narcissistic individual's self-absorption, inaccessibility, and indifference to the analyst [are viewed] not as evidence of an absence of transference, as Freud thought [but] as evidence of the activation in the transference of a primitive object relation, one in which self and object representations are not fully distinct or separate but thought to contain elements of each other (p.173).

Kernberg (1986) suggests that patients with narcissistic pathology develop intense negative transferences. They "resist" treatment through devaluing, dismissal and spoiling in an attempt to deny dependency and keep alive the fantasy that the analyst is not independent from themselves. Kernberg argues that the analyst must focus on this quality of the transference and counteract the patient's efforts at control and devaluation. He cautions that once this transference resistance is undone, the hatred, envy and paranoia of the patient may become active. Kernberg explains that idealizing and mirroring "transferences" are defenses against envy and rage in which the grandiose self is projected or reintrojected to create

these experiences. Kernberg also emphasizes the importance of countertransference reactions with narcissistic characters, noting that "because the patients treat the analyst as extensions of themselves… the analyst's emotional experience reflects more closely than usual what the patient is struggling with internally" (p. 230-231).

Bromberg (1998) also stresses the importance of countertransference with patients with narcissistic disorders, following from his observation that dissociation is a part of all narcissistic pathology and leads to "a self robbed of life and meaning" (p.196). Because these dissociated states are not known to the patient, they cannot be narrated by the observing ego, and therefore they are only revealed in enactments in the transference and countertransference. He suggests that the only way to know the patient's dissociated states is in the data of experience. Ogden (1995) argues that the sense of aliveness and deadness in the transference-countertransference dynamic as the single most important measure of the moment-to-moment experience of the treatment.

Like the experience of transference, countertransference reactions with patients with narcissistic pathology shift over the course of treatment and reflect different expressions of the disorder. LaFarge (1998) explains that, in the early stage of treatment, the patient's grandiosity can lead to a shared idealization, or

else his or her aloofness can evoke boredom or anger. In the middle stage, the patient's rage and paranoia can be painful for the analyst, but in the late stage the countertransferences deepen and become more sympathetic and appreciative of the patient's work.

Gabbard (1998) outlines likely countertransference responses with patients with different types of narcissistic pathology and the appropriate therapeutic action to take in each case. Boredom, he argues, is particularly common with patients at the oblivious end of the spectrum as it is most likely to occur when therapist feels excluded from the internal world. A therapist may feel bored and excluded because of the therapist's own need to be needed and important, which the patient is depriving him of, or the patient may be projecting his own early experience of being excluded and distanced. Therapists need to investigate their own narcissistic needs in this experience, but if they then feel it is a case of projective identification, interpretation of this identification can be helpful. Gabbard suggests that the therapist is likely to feel controlled when treating a hypervigilant patient, and should use this feeling to empathize with the patient's terror that if they are not in control, others will reject and abandon them (Gabbard, 1998, pp.134-139).

Gabbard explains that patients with narcissistic disorders pull for a range of difficult feelings and argues

that it is vital to remember that the core of the pathology is the insecure and poorly developed self. He cautions that,

> interpretations themselves may be countertransference enactments, in which the insight is used as a cudgel to make the patient stop whatever he or she is doing. When such efforts appear to fall on deaf ears, therapists may escalate their interpretive attacks in an all-out assault on the patient's character armor. The patient will simply circle the wagons against the assault and become more defensive and less amenable to expressive work" (1998, p. 141).

Summary

My review of the literature on narcissism and gender suggests that there is an important relationship between the two. Gender differences in narcissistic disorders may shift somewhat with cultural changes, but they may also run deeper and involve the different developmental struggles and bodily experiences of male and female children and their resolutions. These struggles also contribute to a complex and ambivalent experience of gender itself in some individuals with narcissistic disorders. Boys may be more apt to defend against their own aggression and the narcissistic injury of being under-valued by resorting to a condensation of the grandiose self and idealized parent

leading to a more introjective, and overtly grandiose narcissism that interferes profoundly with object relations. Girls, on the other hand, may be overly connected to their mothers and in their attempt to separate from their mothers and resolve their issues of narcissistic injury, may be more apt to experience an anaclitic, object relational form of narcissism which may involve a hidden grandiosity and a pathological body fetishism. This distinction between the male and female resolutions of early conflict is but one possibility. The experience of gender is complex and nuanced, and the development of gender identity involves an integration of masculine and feminine identifications so there may be other gendered resolutions to early conflicts that are relevant to individuals with narcissistic pathology. Each of the possible resolutions and identifications explored in this review may affect narcissistic presentation and influence the transference and countertransference patterns experienced in treatment.

Chapter Three: Methodology

This is a qualitative study of the experience of gender in patients with narcissistic disorders. This study is exploratory with the aim of generating hypotheses and building theory about the intersection of narcissism and gender and the ensuing clinical issues. To explore these issues, I interviewed seven analysts about their experience with patients with narcissistic pathology, the ways that the they understood gender to be experienced by these patients, their understanding of the role of gender in the etiology and presentation of the patients' narcissism and the specifically gendered struggles of treatment. I then thematically analyzed the interviews. In this thesis, I present the material of the interviews, explore the themes that emerged, and discuss my findings in the context of psychoanalytic theory.

Rationale for Methodology and Design

Waldron (1997) suggests that case study research is the most appropriate method for questions of "how and why a phenomenon occurs and for preliminary, exploratory investigations" (p. 292). I chose to use a modified case study approach for my study because of the exploratory nature of my research and my interest in a previously unreported relationship between two complex entities, the

development and presentation of narcissistic pathology and the experience of gender. I believe that this relationship and its implications for clinical work can best be understood through the in-depth investigation the experiences of individual patients as they are understood by their analysts.

Much that is written recently on case study research is based in the psychoanalytic process-outcome research, but case study research has a long history in medicine and science. Darwin developed his theory by generalizing from case studies of organisms in different environments, and our diagnostic categorization of physical illness was developed from accumulated case studies in the medical field (Waldron, 1997).

Critics of case study research often argue that the methodology allows for more bias because the sample is chosen, not random, but proponents suggest that this is in some ways its greatest strength (Gedo, 1999; Leuzinger-Bohleber & Target, 2002; Waldron, 1997). Jones (2001) states that single case research is the form of research most directly based in the tradition of psychoanalytic investigation and offers a unique potential for studying individual patients. Kazdin (1982 in Waldron, 1997) explains that only case study research can provide insights into the individual rather than into a non-existent, composite, “average” patient. He adds, “information about

idiosyncratic features of patients that may be central to their psychopathology or to their treatment is lost in population studies" (p. 292). Gedo (1999) argues that the value of single case research is the choice of a nonrandom, but theoretically and clinically important, data sample to analyze intensively.

The data in this research is from seven two-hour interviews with psychoanalysts who were asked to discuss patients with narcissistic pathology. Prior to these interviews, I reviewed published cases studies to further develop my thoughts on the relationship between narcissism and gender. In my search of published case studies I realized that there are few detailed case studies of patients who are identified as primarily narcissistic. Those that I found, I used as only as background information as pertinent details might have been changed that might affect my analysis of issues of gender, the body and the family structure.

My interviews with the psychoanalysts allowed me delve deeply into the analysts' experiences of the patients and the treatments, and to focus on the analysts' recollections of the patients' experiences of gender. The interviews were open-ended and exploratory and allowed me to follow-up on relevant areas and to elaborate on issues of transference and countertransference over the course of treatment. This depth and focus is not available through the published case

material. The interviews with the analysts focused on particular patients the analysts had seen in treatment and I used these cases as case studies. To attempt to articulate the full range of material presented to me, I did not do an intensive analysis of a single case, but rather evaluated all of the cases using a thematic analysis.

Although I am attempting to understand the experience of a group of patients, I have chosen not to collect data from the patients themselves for a number of reasons. First, I am interested in dynamics that are not conscious and would not be evident in a brief interview with a patient. For example, understanding the experiences of grandiosity and aggression in a patient who presents as over-burdened and altruistic takes a long relationship. And, even an accurate diagnosis of narcissistic pathology may involve a long-term relationship (Cooper, 1998). Second, I am interested in the experience of treatment with these patients and need to speak to those who have worked intensively in the area. And third, because I am interested in patients with a wide range of narcissistic pathology, but may not meet the DSM IV criteria for Narcissistic Personality Disorder, it would be extremely difficult to identify the appropriate population on which to focus.

Addressing this third issue involves looking at the current understanding of narcissism. Currently there is only one form of Narcissistic Personality Disorder codified in

the DSM, but there are at least two types of narcissism seen clinically: overt and grandiose and covert and vulnerable. Most of the research on narcissistic disorders has been done on overt type typified in the diagnostic criteria of the DSM IV, even though it is now understood this form of the disorder does not sufficiently represent the range of narcissistic pathology seen by clinicians (Morey & Jones, 1998; Ronningstam, 1998). There is currently no measure of narcissistic pathology that accurately represents the full range of narcissistic disorders (Wink, 1981). And, Cooper (1998) argues, even "structured interviews, self-reports, and single interviews may have difficulty capturing the phenomenological range of narcissistic pathology" (p.61). Cooper (1998) suggests that repeated clinical contacts may be necessary to fully assess narcissistic pathology. Identifying a range of patients with narcissistic pathology is therefore quite a daunting task.

To further complicate the matter, I am interested not in a diagnosis, but in the interplay between the expression of all forms of narcissistic pathology and the experience of ambivalence around gender. Stuhr (2002) states,

> As we know, opposite phenomena and contradictions are often connected in psychology (the phenomena of ambivalence). Love and hate, autonomy and wish for closeness; they cannot be separated from each other in a strict logical way, such as by the negation that

statistical procedures afford (p.112).

To collect the data for this investigation and for its analysis, I used qualitative research methods. Given the exploratory nature of the research, the complexities of the subject matter and the limits of existing empirical measures of even the basic concept of narcissism, this seemed the best way to explore my topic. Jones (2001) suggests that qualitative research is primarily useful for discovering new information and developing principles. Strauss and Corbin (1998) suggest the use of qualitative methods for

> research that attempts to understand the meaning or nature of experience or persons with problems…[or] to explore substantive areas about which little is known or about which much is known to gain novel understandings. In addition, qualitative methods can be used to obtain the intricate details about phenomena such as feelings, thought processes, and emotions that are difficult to extract or learn about through more conventional research methods (p.11).

Stuhr (2002) argues that qualitative research is crucial for analytic research because, in quantitative research,

> Statement A, for example an item on a questionnaire or an observation has to be defined without contradictions within itself. But we know… that there are language

> phenomena such as paradox and the oxymoron, similar to that ambivalence, important to psychoanalysis, which cannot be described by formal logical systems such as algorithms. This means it is not necessarily the complexity of the subject, but the logic of 'unmistakable unequivocal statements' that limits traditional quantitative psychotherapy research (p.112).

As discussed above, Narcissistic Personality Disorder has been empirically studied, but I am interested in a full range of narcissistic pathology, which may be difficult to pinpoint, and I am attempting to understand the greatly undertheorized experience of gender in these patients and the role of gender in the etiology, manifestation and treatment of their disorders. To understand these issues, a subject base consisting of analysts who have had the opportunity for a long-term evaluation of patients' pathologies, and a qualitative method that allows a full exploration of the relevant clinical material are crucial. The interviews are also appropriate as there are no formal hypotheses to be tested in this dissertation.

Participants

Participants were recruited through the personal and professional contacts of the researcher. Each participant

was contacted by letter (Appendix A) and a follow-up phone call. Participants were informed that the investigator is a doctoral candidate in the Clinical Psychology program at the City University of New York. They were informed that the purpose of the study is to develop a better understanding of male and female narcissistic patients and to elaborate on the issues of treatment with these patients. They were also told that they would be asked to discuss specific clinical material.

The seven participants in this study, three men and four women, are all psychoanalysts in private practice in New York City. Five trained as clinical psychologists, one as a psychiatrist and one received a doctorate in another area and respecialized. The participants are on the faculty of various analytic institutions including: American Institute for Psychoanalysis, The Columbia Center for Psychoanalytic Training, The New York Freudian Society and Psychoanalytic Society, New York Psychoanalytic, New York University Postdoctoral Program in Psychoanalysis, Institute for Psychoanalytic Training & Research (IPTAR). Five of the seven are training and supervising analysts. The subjects have been in practice as analysts for at least 15 years.

All of the subjects work with adult patients (some also work with children) and all of the clinical cases discussed in the interviews are individual psychoanalytically informed adult treatments. One subject discussed a case that he had

supervised for many years.

Research Materials

The primary instrument for this study is an interview (see Appendix B). I did three pilot interviews to develop the interview. From the pilots I realized I needed to ask for specific case material for two patients—one male and one female—rather than asking for thoughts on male patients with narcissistic pathology and thoughts on female patients with narcissistic pathology. The interview is designed to communicate the researcher's primary interest in the clinical experience of the participants. The questions are broad and allow the participant to drive the data.

This research is exploratory and it was therefore important that the participant and researcher were allowed to be spontaneous and follow themes as they emerged. However, a framework was necessary for both the participant and the investigator in order to gather information efficiently. The primary task of the interviews was to understand the experience for the narcissistic patient and the analyst of narcissistic pathology as it relates to gender. The goals were: 1) to develop an understanding of the experience of male and female patients with narcissistic pathology; 2) to understand the role of gender in this experience; and 3) to learn something about the issues of treatment as it relates to issues of gender. Based on these

goals, the interview was loosely divided into three sections: a description of male and female narcissistic patients, the role of gender in the pathology and the experience of treatment. As each section developed, questions became more specific to address relevant areas identified prior to the interviews. As stated, the interview were structured as a research interview to insure topics are covered, but the sequence in which the material unfolded varied and the "sections" were transversed as needed.

Procedures

All interviews were conducted by the researcher. Once interest in the study was established, each participant was told that the interviews would take approximately two hours and would be recorded and transcribed. The participants were informed that the research was clinically focused and were asked to consider discussing clinical material in a way they felt comfortable. They were told that all information would be kept confidential and that identifying information would be altered when the material was presented in written form. Participants were also informed that they would be given an opportunity to review the results section of the dissertation.

The interviews took place in the private offices of the participants. Each participant signed an informed consent

form (see Appendix C) before the interview allowing the researcher to record the interview and transcribe the contents. Prior to data collection, the study met the criteria of the Institutional Review Board of the City University of New York.

Each interview began with a brief introduction of the topic through the clinical experience of the researcher. The interviews then moved onto the clinical experiences of the subjects. The interviews lasted between ninety minutes and two hours each. At the end of the interview, most participants commented that they had found it interesting and enjoyed discussing the case material in this way.

Data Analysis, Coding and Presentation

As qualitative data analysis requires a careful, thorough examination of the raw data of the interviews to find patterns and understand meaning, the interviews were transcribed verbatim. The transcribed material was then read and re-read several times by the researcher in order to create an initial organization of data into major themes. Certain common experiences stood out and were flagged by the researcher.

Each interview provided a number of case studies and each case was then separated out and reviewed. For each case, the researcher determined presenting issue, core issues that arose later in treatment, type of narcissistic

disturbance, gender issues, family dynamics and treatment struggles. These key areas were then compared across cases to develop groupings in each area. Cases were grouped by the sex of the patient in order to analyze male and female patterns, but differences in experience were also used to guide the groupings as the gendered piece was more complicated than first expected. Themes that emerged from individual cases were then considered across cases and across subjects. Specific words used to describe the patients and the experience of treatment were also noted and reviewed for patterns.

The data is presented in two chapters for greater clarity. The first chapter outlines the relevant terms, provides a brief introduction to each analyst and presents relevant clinical material from the cases as they were presented in the interviews. This chapter will give a case-by-case analysis of the material. The second chapter presents the major themes across cases and provides an analysis of the key areas of struggle as they arose in the material. Subjects' thoughts about the intersection of gender and narcissism are also presented in this chapter.

Chapter Four: The Interviews

In this chapter I will present case material from the interviews that illuminates a complex experience of gender for a subset of patients with narcissistic pathology as that experience is interpreted and narrated by their analysts. I will briefly discuss my use of the terms narcissism and gender, and will then present the clinical material from the interviews. I will ground each case presentation in the theoretical perspective of the analyst. While I asked each analyst to present one male and one female patient with narcissistic pathology, the interviews were rich conversations and many of the subjects spoke about more than two cases. I will discuss those cases in which the interplay of and conflicts related to gender and narcissism were most vivid.

Defining the terms

Narcissism

I asked the subjects to provide their own clinical definitions of narcissism and to discuss a man and a woman, whom they saw as primarily narcissistic. My goal was to elicit a wide range of patients with narcissistic pathology rather than a single type of narcissist, and to allow subjects to speak about the patients who stood out for them most powerfully as narcissistic. I chose not to present a

version of narcissistic disorders during the interviews because I wanted to illicit the analysts' expertise. This allowed the subjects to present patients with a wide range of what they considered narcissistic pathology, but also allowed for their idiosyncratic views on the subject. Each subject gave me a general working definition of narcissistic pathology and then discussed specific issues for the patients presented. The definitions of narcissistic disorders that the subjects provided were based in their clinical experiences. Although each subject had a clear sense of how he or she saw the pathology and how it affected treatment, the preliminary definitions were not generally diagnostically detailed. The subjects' definitions of narcissistic pathology included: an over investment in the self; a disturbance in the relationship to self and to others; an unstable sense of self that is easily damaged; a conflict over whether being attuned to another will destroy the self; a disorder of self-esteem regulation; the inability to see beyond one's own pain; a pathology of the self; being hooked on the external; a fantasy of one's own perfection; and an experience of extreme shame along with a lack of a sense of a differentiated other. The differences in these perspectives are presumably connected to the subjects' theoretical orientation, but these definitions are also largely phenomenological, and reflect one aspect of the experience of the analysts with the patients. While these

definitions echo some of the diversity of ideas about narcissism in the analytic community, it is surprising, given the classical training of some of the subjects, that no one used the language of the ego and superego or provided a structural analysis discussing the level of organization of patients with narcissistic disorders.

Although the subjects' definitions vary in focus, the patients they describe as having narcissistic pathology share common struggles. They are people with fragile senses of self, which they attempt to bolster externally. They can present as grandiose and entitled or depressed and depleted, but regardless of presentation, they share an inner experience of emptiness and worthlessness and are overly invested in a rigid ideal. They tend to be unable to relate to others as integrated whole people and they idealize or devalue other people to maintain their self-esteem. Most subjects report that however the patient presents, after years of experience, it is clear to the analyst that the patient is narcissistic early in the treatment. As one subject put it, "if a real narcissistic personality walks through the door, you know. It's unmistakable." The condensed experience of these well-established analysts, and their ability to clearly identify their patients' core issues as narcissistic, irrespective of presentation or severity of pathology, grounds this work and allows me to explore the gendered dimensions of the pathology.

The analysts identified patients from their lifelong caseloads to present to me because they stood out as narcissistic and exemplified something about the disorder. The patients with narcissistic pathology whom they chose have a wide range of symptoms and different struggles and appear to have differing levels of organization. Some appear close to neurotic while others appear to have a lower-level borderline organization. The analysts, however, do not make these distinctions and given that disturbances may appear more severe in treatment, it is not possible to accurately assess each patient's level of organization. However, it emerges from the cases presented, that there is a conflicted experience of gender across a wide range of narcissistic pathology, from patients with delusional symptoms to high functioning patients.

Gender

Gender, like narcissism, is a word that has many different meanings in our culture. In this thesis I use the term gender to encompass the experience of ones' anatomical and genetic sex (being biologically male or female) and the experience of ones' sense of maleness or femaleness which includes deeply felt ideas about what is masculine and what is feminine. Discussing the terms masculinity and femininity, Dimen (1991) asks, "If… we assume nothing about gender other than that it is a socially and psychologically

meaningful term, what meanings can we find for it?" (p.349): that is, what matters is not the "fact" of a patient's gender, but their internal, personal understanding and experience. In this thesis, I explore meanings and conflicts as they emerge from the analysts' reflections on their patients' experiences of gender. These experiences involve personal ideas about being a man or a woman and the meanings that those have to the self and in the larger world. To allow for the breadth of experience, I will stay close to the language the analysts used with me when reflecting on their patients' experiences of gender. Inevitably their descriptions are imbued with their own interpretations and transference/ countertransference experiences, but I used these integrated summations to understand the nuanced meanings of the terms masculine and feminine and the experiences involved in being male or female.

The Patients

As subjects described their male and female patients with narcissistic pathology, a large set of conflicts/issues around masculinity and femininity emerged. This group of patients shared an experience of gender ambivalence, a quality of not being or feeling fully male or female, that is part of their struggle to engage in work and

relationships. Developing a sense of ones' masculinity or femininity is a process, implicit or explicit, for all people, and it may be difficult for many, but for these patients there is an ongoing struggle manifested in a disruption of the self and a feeling of inauthenticity in their maleness or femaleness. In some of the cases the struggle becomes apparent in the experience of the physical body and in other cases the issues involve an over-investment in an idealized version of masculinity or femininity and are more evident in the transference.

In the following section, I will present material from these cases to highlight the specific quality of the intersection of narcissistic pathology and the struggles in the experience of the body and the gendered self. For each case, I will address the relevant developmental and dynamic factors in the patients' lives and discuss the analysts' experiences of treatment. I have divided the cases by subject and will contextualize the material by providing a brief summary of each subject's views on narcissism before presenting the material.

Dr. T

Dr. T is a male analyst who defines narcissism as an overinvestment in the self, which causes negative affects. He frames his thoughts in terms of compromise formation and

asks, “Does the investment in self somehow help the person to get more pleasure? Does it lead to dysphoric affects? Does it create guilt? Is it adaptive?” He argues that narcissistic disorders vary in their degree of severity and in terms of their pervasiveness in the character and says,

> I think that somehow, sometimes what happens is the narcissistic pathology is, not encapsulated, but sequestered in one aspect of their personality with symptomatology often in the sexual realm in terms of some preoccupation and so forth, and… allows them to have ‘healthy relationships’ and a satisfying life.

A vagina in the abdomen: a man turning into a woman

Dr. T presents a male patient who believed he was turning into a woman. This man sought analytic treatment because of a set of physical preoccupations, which included seeing his body changing into a female body. Dr. T views hypochondriasis as a narcissistic symptom because he argues it is a preoccupation with one’s own body due to all of one’s libido returning to the body. Dr. T explains that while this man was very disturbed, he saw his pathology as primarily narcissistic, an overinvestment in the self, at the level of the body. Dr. T saw this man in four times a week analysis for about four years.

According to Dr. T,

> This was a man who had some very disturbing, almost delusional symptoms having to do with the sense of his body, that he was turning into a woman, and he would look at himself in the mirror and feel that. What's interesting about this patient was, he was losing his pubic and maxillary hair, he was turning into a woman. He had all sorts of diseases, you know. It certainly bordered on the psychotic, and you could say, okay, what's happened is because he's exquisitely narcissistic, all the libido is returning to his body.

Dr. T explains that this patient's father was a weak, passive man and "his mother was extremely intrusive to the nth degree, hovering over him." The patient saw his mother as all-knowing and all powerful, but it became clear in treatment that she was actually very superstitious and fearful and worried all the time when the patient was a child that he would injure himself with physical activity. When this man was little boy his mother had another baby, a little girl whom his father adored. Dr. T argues that the patient's symptoms,

> had to do with the memory of his sister who was preferred by his father. And, turning into a woman also was a way to deal with Oedipal anxiety as I

> understood it, we understood it…. It's not that you want to turn into a woman, but if you're a woman then you're safe from the castrating fear of your father. [But it was not just the father, but the mother] and I think one of the things that in the symptom we understood [was] the idea, that in his hypochondriac preoccupation, his body was himself as a child and he was hovering over his body as his mother hovered over him, so there was a repetition of that relationship with the intrusive mother. So, I mean of course, you know, in a way his mother viewed him as an extension of herself, so you have an extremely narcissistic mother, and narcissistic in the sense that she could not accept the separateness of her child, but her child was there to fulfill her own needs and wishes [and then becoming a woman is an] identification with her, and he was her.

This interpretation of these symptoms as a form of identification was further supported by the fact that the patient's symptoms frequently mirrored those of illnesses his mother had developed when he was entering adolescence, which was a period of great anxiety for his mother. Dr. T explains,

> The patient came to understand that his sexuality had been discouraged by his mother because his maturity

> meant he would leave her for another woman. Fantasies of a vagina appearing on his abdomen suggested he would be willing to give up his penis altogether in order to please her. The patient's feminizing was understood as a way to avoid separation from the preoedipal mother by identifying with her.

Dr. T describes this patient's fear of/fantasy of disease as "a narcissistic symptom because it has to do with the libido sort of turning back against the body." Dr. T also relates that this man had a sense of specialness and power throughout his boyhood. He recalls a memory from the patient that he experienced as illuminating the man's narcissistic fantasy. When the patient was about five years old, his grandmother got very sick and the patient remembers saying to her, "don't die Grandma. Look at me in my sailor suit." Dr. T argues, "okay, now I would say that's an exquisitely narcissistic communication with the idea that somehow this investment in the self would ward off separation and loss of the object."

Part of the man's physical preoccupation involves his belief that he is physically becoming a woman. This was not an internal experience of himself as female, but rather a physical experience—he could see his body changing and becoming the body of a woman. Dr. T and the patient came to understand this patient's experience as stemming from an

over-identification with an extremely hovering, intrusive mother from whom he was unable to separate. His identification is also understood as a response to her fear of separation coupled with the unavailability of his weak father for idealization. The feminine identification is potentially also associated with the envy of the adored younger sister.

Dr. T saw this patient in analysis for many years and the transference was multifaceted. Dr. T reports that the patient saw him as both a savior and a life-sucking leech. The patient believed that since he was seeing a medical doctor (the subject is a psychiatrist), he could not be that sick physically (and would not die), but also believed that the analyst was sucking his blood and draining him of life. In the transference, the patient attempted to idealize the analyst and his role as physician, but the conflicts concerning how to be a man and the identification with the mother often prevailed.

The duffel coat: a man surprised by being loved for his manliness

Dr. T discusses a second male patient who appears to struggle with the appeal of his masculinity. His conflict around gender was less evident in his presentation but he too struggled with identification. This man presented for treatment because he was dissatisfied with his work, was

unable to be creative, and had never had a sexual relationship. Dr. T says that the man was not satisfied with his achievements because he did not get the admiration of others. He was also preoccupied with his body. "He had an undescended testicle. He had a wandering eye. He felt effeminate as a kid. There's a lot of body preoccupation and the same kind of exquisitely intrusive mother" as the previously discussed patient.

While in treatment, this man began to have sexual relationships with women, and he eventually married a woman with whom he had a child. Dr. T explains,

> He has this sexual preoccupation, which is essentially homosexual, but it's not homosexual in terms of homosexual activity and gratification, it's homosexual in the idea that he has an interest, he's turned on by the body of masculine men, and involved in some domination/submission interaction. The reason that he really loved about his wife was that she loved his armpits. And the idea that a woman would like something smelly was very, very gratifying to him.

This man's narcissistic issues are reflected in his preoccupation with his body. There is also a powerful transference component where this patient's need to find his masculinity becomes clear. Dr. T explains that the patient

needed to identify with an idealized masculine object.

> To what extent he gets that from me [I don't know]. It's very interesting because once I met him in the elevator, and I was wearing this duffle coat and somehow it wasn't so chic and he was very disappointed seeing me in a duffle coat. That was a very important thing that we talked about, his need for me to be this figure that he would look up to.

In this case, the issue of the transference is in the forefront. There is a need to be able to idealize and identify with a powerful masculine figure. He struggles in treatment when he is disappointed by the reality of the analyst as a man who does not wear the perfect male coat. This man does not feel he is a woman, nor does he want to be a woman, but he is drawn to the muscular masculinity of other men and is surprised and excited by having a woman attracted to something masculine about him.

A woman who sees her body as a visual object

When asked to discuss a narcissistic woman, Dr. T struggles to think of one. He explains that his practice is largely male. But, as he thinks, he begins to talk about an attractive woman who came to treatment because she was unable to be creative and was struggling in her

relationships. Dr. T sees this woman's inability to create as a narcissistic issue and describes her relationships as narcissistic rather than object-related or mutually loving and respectful. Dr. T says that this woman experienced her body as an object and could not feel pleasure. He explains that in this case, the narcissistic investment was clearly denying the patient pleasure. Dr. T saw this woman in analysis for about four years.

This case has both the embodied struggle of finding pleasure in the physical body, and a powerful transference component related to becoming more productive and symbolically having a baby. Dr. T reports:

> What I remember is a great deal of inhibition. A great deal of inhibition. I mean, she could be sexually promiscuous but not really invested in the behavior or in her body…. It's a visual object for her, rather than something that brings pleasure in a more satisfying way.

Dr. T explains that this patient's father was a photographer and took nude photographic portraits of her as a young child and these were around the house as she grew up. Dr. T describes the family dynamic as follows.

> Her father loomed large. I think her mother wasn't

there. As I remember, very little came up about her mother. Very little, very little. Her mother was, as I recall, a shadowy figure who lived in the shadow of her husband… I think obviously she was more the favorite of her father so then there was the issue of becoming her father's favorite, being her father's favorite, creating something and surpassing her mother, and the impact that that would have on her feelings for her mother in the family constellation.

Dr. T describes her inability to be creative and to seek a certain kind of pleasure.

There was a narcissistic dimension to her inability to create and show off herself and it was because on the one hand, she wanted so much…. There was another dimension, which we have to think about whether it's related to narcissism or not. That's the voyeuristic, scopophilic dimension of creativity and writing, you know, and revealing things about herself. And so that was very conflicted for her, and she was very hard to get out of that box. Now, so we talked about that. In other words, could she be an artist like her father? But of course, her father, you know, exploited her, and if she was a successful writer her parents would be pleased with what she was doing, but then she wouldn't be doing it for her, she would be doing it for them.

> So that was, I think, certainly a narcissistic part of the economy of the relationship.

In this case, Dr. T explains that the work in the transference was in the conflict about the patient's wish for her father and the effect that had on her ability to be creative. This conflict also affected her capacity to feel fully female and is related to her creativity because creativity seems to require an embracing of her feminine productivity and an integration of the powerful father.

> There was, I think, a need for me to admire her and a feeling that she shouldn't have that need. I mean that was really the – that she wanted me but she shouldn't. Just like she wanted her father to marry her, but she didn't want to want it. So that was really the transferential central core in a way and that would come up again and again and again.

Dr. T reports that the treatment allowed the patient to become more productive and to write, and both he and the patient saw her first book as their baby. Dr. T says,

> The first thing she wrote was a pornographic novel…. Certainly what it seemed to us was that this first product was for her a baby. It was our baby. The pornographic novel was our baby. Because we certainly talked about sexual things in here. But somehow this was a kind of like a bridge experience, and there was

> something about the economy of that production which enabled her to have something for herself and to give something to me. So that was what was important and then she could go on.

The production of the pornographic novel also seems important as a way to express both the aggressive and the libidinal experiences.

Interestingly, Dr. T describes this woman's narcissism as more "malignant" than some patient's with more extreme/severe symptoms, like the man who believed he was turning into a woman, because it is not compartmentalized and affects her work and her relationships so pervasively.

Dr. J

Dr. J, a male analyst, defines narcissism as "a pathology of the self" and of the feelings about the self. He suggests that narcissists have an internal experience of emptiness, inferiority and hopelessness, rooted in inadequate mirroring or reflection in childhood and/or early trauma, which may be defended against with grandiosity and over-entitlement. He argues that narcissists are "hooked on someone external to them. It's not inside." The inflated narcissist needs someone to "reflect him and mirror him and tell him what to do. Whereas the deflated narcissist is hooked on someone to idealize." Dr. J suggests that, "over the course of a

successful treatment they begin to rely on something that's internalized."

Monster or patient: a man who felt like a woman

Dr. J describes a narcissistic male patient who came to treatment expressing the more deflated side of the disorder. This patient sought treatment for depression and a lack of agency. He also had the experience that he felt like a woman. Dr. J saw him in analysis for 10 years. This patient was quite successful in the world, but internally could not experience his successes. Dr. J reports that the man had no sense of continuity of experience. He recalls the patient saying later in his analysis,

> Do you remember how I used to feel that when I turned on the water tap, blood might come out? I used to marvel at how certain you seemed when you came out into the waiting room that you would find me there, and not someone else, a plant, or a monster.

Dr. J explains,

> This guy... felt like a woman. Even though he was married, he was having sex with his wife and so forth, that wasn't his experience. He had a very unclear gender I think…. He idealized women, and he thought that they were wonderful and that a man was nothing, and that he would like to be a woman. That was very

> clear. He said that over and over again. He should have been born a woman, he would like to have been a woman. Looking at him you could never have told. He was a very tall, handsome, substantially built guy, who didn't walk around like a woman or anything, but that was the way he felt, and that was the way he talked about it.

Dr. J describes the family as follows.

> The father was scarce. He was there, but he was not an important figure in this guy's life. It all had to do with the mother. The father was visualized as a little washed up thing. And the father in fact had not been successful in life. [The mother was very disturbed,] kind of a borderline at least. Intensely involved with the patient. And would radically shift her own feelings from one moment to the next. It's what you would have imagined with somebody who has such a sense of the possibility of change; [who] can't really believe that the sun is going to come up the next morning, and the sun is his mother.

Dr. J understands the patient as a narcissist who feels depressed and empty. He is a man whose narcissistic issues are evident in his disturbed sense of self and his inability to experience his own achievements and to feel himself as

continuous. While he is externally masculine and reality based, internally there is tremendous conflict and the feeling that he "should have been born a woman." It is not clear how this experience affects his physical sense of himself, and the patient does not report physical symptoms or issues with his male body, but there is some fantasy, some wish to have been born female and an experience of feeling female. His mother is described as over-involved with the patient, and very crazy and the father as a failure, "a washed up thing." Here again the patient is the Oedipal victor, but he has so idealized women and so over-identified with his disturbed mother that he becomes unclear who he himself is on all levels of experience.

Dr. J discusses the difficulty of treating this patient given his lack of object constancy.

> It was wild. It was actually wild, because we lived through all of that craziness. There were some days I was a monster, and some days a benevolent person…. He didn't know who he was either…. It was mixed in and out of idealizing transference and mirroring transference… a lot of rage when things didn't go right.

Dr. J believes that through the consistency of the treatment the patient was able to better regulate himself

and his experience and develop a stronger sense of continuity of both self and other.

A woman who believes she couldn't possibly have a baby

Dr. J also presents a woman who had much less severe symptoms but was confused about her capacity to be fully female. She acted and appeared feminine and did not question the fact that she was a woman, but she could not imagine how a baby could come out of her body. Dr. J describes her situation as a case of

> a woman who's ungendered…. You would never know it from the history. She was indiscriminately sexual in her adolescence. She has always had, she's a very attractive woman. She has always had men, boyfriends…. [She was] someone who grew up with a nutty mother who used to sleep naked in bed with her all the time, and show her, "this is where you came out when you were a baby…." She's now married and has a child. All of that had something to do with her becoming gendered. But there was a time, many years in the treatment, when she never could even imagine having a child. How could it come out of her body? She couldn't figure it out.

In this case, there is a physical, bodily question — how can my body give birth? — that seems tied to a weak internal sense of femaleness, of herself as a woman. The

subject describes this patient as “ungendered,” something he argues is due to narcissistic pathology, a pathology of the self, occurring prior to the development of gender identity and therefore impeding its authentic development. Dr. J explains that while this patient acts feminine, she feels she is missing something core to being female. The intrusiveness of her mother seems to have robbed her of her separate female self — she can go so far, but no farther in becoming/being a woman. Through treatment, Dr. J reports, this patient became more gendered and, as noted, was able to get married and have a child.

Dr. A

Dr. A is a female analyst who defines narcissistic pathology as a lack of enthusiasm about the self, which is connected to feelings of extreme shame. She thinks about narcissism developmentally and says,

> I think the way the other, the important attachment figure, other person responds, contains or mirrors, or you know, like in gurgles, sense-marks what the baby does is taken in by the baby as what the baby does. And if there’s a resonance, that’s great, or a soothing containment, but if there’s a mismatch then there’s real confusion about… – why is there that difference in what it feels like in the body and what it looks like

> it's feeling like from the outside? And there can be confusion, and then I think there can be shame, like some sense that when the prohibition is understood, the idea of a "no," and there are things that are wrong, that is applied to the self, too, "There must be something I did wrong, or something wrong about me." That goes to shame, shameful feelings.

Dr. A argues that there can also be early narcissistic pathology that has to do with there not being good enough development of the differentiation between self and other. She describes narcissistic people saying,

> You don't have a sense that they have an idea that there's another person, or a capacity to hold in mind that there's another person there, who has to take in the information. You know, they're just within their own sphere.

<u>God don't take this child it is a girl: a man's gender confusion</u>

Dr. A describes a narcissistic man who came to treatment after starting a relationship with a woman that he really wanted to work. She has seen the patient for about 12 years in three-times-a-week analytic treatment. When he began analysis he had been fired from a number of jobs and

was under-employed as an “errand boy” for a civil servant. He struggled in both work and love because of his sense that he should always be the boss and get the credit. Dr. A explains, “he was someone who really is a brilliant talented person… and then he just became a kind of marginal person. Could never make anything of his career.”

In treatment it became clear that this man had some significant gender confusion. He was unclear about himself as a man. Dr. A reports,

> He was the oldest and he was definitely the special son for his mother…. He was so perfect. So beautiful, so perfect. But the beauty was that he looked so much like [his mother]. So there was this real confusion about himself that way, and he would talk about himself like, you know, if he wanted to be successful in an interview, he would talk about wanting to look attractive in the way that a woman would talk about it, wanting to have a pretty look to his face.
>
> He had terrible feelings about his penis, which he thought was damaged and too small, and there was some question about whether there really was some kind of anomaly, and at one point very early on in the treatment he had some mysterious surgery done to his penis, but still he has a lot of trouble having erections. So he was in this relationship with a woman

and had very serious questions about his own gender.

> [His father] was very remote. The myth was that the father didn't want to have a child, and the mother really did, so he was kind of born against the father's will. And the father was always jealous of him, in his eyes, or his relationship with the mother, and the mother's love for him, and he felt much smarter than the father, but at the same time very rejected by the father who was really good mechanically and would do all sort of fix-it projects in the house, and he felt very excluded from those, like he wasn't man enough to do those.
>
> His mother was very controlling, and he always felt that he was the Oedipal victor, that she definitely loved him more than she loved his father.

Dr. A describes the mother as very intrusive. She gives as an example that when this patient was a toddler, his mother gave him very painful enemas.

Dr. A recalls a crucial family story for this man. She says,

> He remembers once crossing the street, or learning how to cross the street by himself, and his mother saying something like, I don't know if this was true or he imagined it or what, but he reported it many times as a

> true story, that his mother said, “Be careful,” to him, and then, “God, don’t take this child, it’s a girl,” or something like that.
>
> He saw [his mother] pretty regularly. He went back up to where they lived, and he would always come back very, very disturbed. Like in a very different state, with real gender confusion.

This man’s narcissistic issues are reflected in his professional and personal struggles. He is unable to tolerate being directed by other people or to acknowledge his own limitations.

> He really thought he was going to be an astronaut or the president. And anything less was… he couldn’t understand how it could be that he wasn’t. If only people knew, then he would be. And that was his conscious experience of himself.

Dr. A explains that even as a child, “he would figure out all these different ways to make up for a way in which he wasn’t the best, so that he could indeed be the best.”

Embedded in this patient’s narcissistic struggles is confusion about his gender. This is a man for whom concerns about gender are expressed in complaints about his physical maleness—there is something wrong with his penis — and in confusion about the internal sense of himself — his is a

female beauty and he is so like his mother. It is not clear from the interview how the two struggles intersect. Perhaps his grandiosity represents a defense against the feminine and/or his wish to in some way be both male and female may be another attempt to deny limitations.

The man's mother was extremely controlling and physically intrusive, and he was the Oedipal victor over a weak, uninvolved father. In this case the mother appears also to have had very powerful feelings about her son's maleness and he, in turn, is deeply conflicted about being a man. The prayer of protection that his mother uses is tied to the denial of this man's maleness, and raises the conflict of who to be on many levels.

Some of these issues were evident in this man's fantasy life. Dr. A explains,

> The fantasy would be that there was a woman and he would be having sex with the woman, or he would be attracted to the woman but then not be able to satisfy her. And then these big, either one or more big, strong men would enter the scene and rape her, and rape him. So we had long periods of analyzing the aspects of that, that had to do with, you know, the Oedipal aspects, the punishment of his wishes, the wish to be penetrated himself, the reenactment of the enemas. He still has a lot of difficulty with feelings, and so

> with feeling aroused, and also kind of feels like as soon as he has any feeling of interest in a woman, that means he has to have sex with her and get married. What he did come to actually was some idea in the treatment, was that he would really like to be with a woman who has a penis, that's what he would like, and to be penetrated anally by her. It's not that he wants a man, but it's not that he wants to penetrate a woman either.

Dr. A describes being the only person who knew all the parts of this patient — his secret life and his visible life. She describes part of the success of treatment as the patient having had the experience of being seen for his whole self. The continuity of sessions was vital in helping him to enter the world.

> Actually my very first experience, I remember talking about this with a supervisor, was being really afraid. I sort of didn't know where he came from, I didn't know the person he was talking about [who referred him], and he was so… he wasn't psychotic, really, but I felt like, this could be a serial killer, you know? He had this mild manner, and way of talking about rage, like he was so unaware of it, and no feeling about [it]. He had no idea. He really didn't experience feelings at

> first. So he made me very anxious at first. And he was convinced if he did this, if he complied and he did this well, he would be able to be in this relationship with this woman. I would make that happen. You know, he would get an A in it. And then that didn't happen, but I think he had enough of an experience in the treatment that, you know, of being seen, really, and being more whole, I think, because he had all these fragmented parts, and he had told me about [writing pornography for money], and I was the only one then who kind of knew everything about him, and so I think it was a very compelling experience to be really seen.

Dr. A struggles in the beginning with this patient because he seems so disconnected from his affect and from the treatment. Dr. A suggests that the consistency of the frame of the treatment and the experience of being seen without intrusion allowed the patient to become more integrated.

> At first I think I was this authority person who he would submit and comply and… and actually lying on the couch was a real submission, and he wound up not doing that after awhile. He was somebody who would lie on the couch and then pop up, you know, or he'd sit on the couch for a long time, and very reluctantly lie down, and eventually he didn't do it at all. I think I was

> this authority person who was going to teach him what he had to know, and he would take it all in – he would actually make tapes – like self help tapes that he would make himself about things that happened in the session, and he would play them to himself on his way, or walking around the city…. And he had fantasies of being a fascinating case to me at some point, but also I think at the same time there was this other part of things that was developing, where I was a real object to him, you know, a real helping person object, and that was more the aspect of the transference I think that had to do with, how was he going to ever find me? How was he going to get to me – he couldn't get to me, you know, he was just beginning to see I was there.

In discussing these elements of the transference, Dr. A highlights the patient's fantasy of being the fascinating, grand case and also his fear of being lost. It is interesting to consider how Dr. A's femaleness played into these dynamics. One can imagine that her position as an authority was exciting and terrifying to the patient and that part of his struggle, as Dr. A mentions, was to learn to relate to her while retaining his masculinity.

<u>A woman who feels she is always being watched</u>

Before presenting a female patient, Dr. A explains that

the narcissistic women she has seen tend to be more related, less “out of it,” than the men she has seen. She goes on to describe a woman who was able to form relationships, but who experienced extreme feelings of shame. Dr. A says, “there was always an idea of another person watching her, and an idea of how she looked to the other person.” This woman presented for treatment because she was unable to work with intention and was quite self-destructive. Dr. A explains that the patient would hurt herself after some “enraging shameful” event. This woman was easily humiliated and could not feel her own value. Dr. A says,

> She couldn’t believe that she had any worth at all. It was a degraded experience of herself, though she saw that people recognized what she did and what she said as very talented and valuable. She knew that that was true, but she didn’t really feel it.

Dr. A describes this patient’s childhood as one in which she felt there was no place for her in her family. She did not feel able to identify with either her mother or her father, and although her mother actively raised her brothers, she was raised by a nanny.

> In my patient there was the sense of the mother always thinking about someone else, not really feeling thought about by her…. There was a real divide in the

patient's experience of the family, of the mother and younger brother as being like, artistic, beautiful, and the father as being kind of obsessive intellectual, and the other brother being there, and she had no place. And she didn't want, you know, if she was with one of them then she'd lose the other, but she felt more like she wanted to be in the mother's and the younger brother's camp, but wasn't really let in there. And she was very smart and intellectual also.

And there was also this sense that her body was not like her mother's body. You know, she had large breasts and was bigger, and her mother was this very petite woman, so there was this feeling like they didn't fit. They didn't match. Actually I think she liked that, that she had bigger breasts. There were things about her body that she felt really good about, and powerful about, and sort of like she had won the competition with her mother, and with me. But it also made her feel, in an Oedipal way, too, I think, like that was something very dangerous. That also contributed to why she wasn't loved by her mother.

Dr. A says this woman used her clothes to help maintain a sense of self.

There was a lot of focus that she had on what would she wear, and how to, sort of, how to put herself together

> externally so that she would feel okay. And okay in terms of how she would be seen by others, but also, I think, consistent to herself. And she would wear the same clothes. Like she had sort of five tee shirts that were the same style but different colors, and she would alternate those. And you see that in little kids when they don't want to change their clothes because it's like the skin ego kind of thing, and it was very much like that for her as an adult.

Dr. A reports that every night this woman laid out an outfit and shoes by her bed, so that if there were an emergency and she had to leave her home she would not be seen in a state of disarray.

This patient's narcissistic issues are reflected in her extreme experience of shame, her sense of worthlessness, her need for external validation and her inability to create. Dr. A explains,

> She couldn't intend to do something. And so that whole experience, that's like the real narcissistic phallic experience, you know, the 'I.' 'I'm going to do something.' She couldn't do that.

This woman does not feel her talent even as she knows it to be present. Like her belief in her talents, her sense of her physical self is easily disturbed. She struggles with feeling her own experiences, and she easily feels that they

can be overpowered by the perceptions of other people. It is so difficult for this patient to experience being known without being taken over or rejected. The fragility of the self makes her feel that if there is anyone else being thought of she cannot have a place.

The patient's concern about her place in the presence of others became evident in the transference. Dr. A explains the importance to the patient of being the one person in her analyst's mind. She says,

> I have the sense that she never had that, 'You are the wonderful apple of my eye' experience… And I think that there's some compensation in her, you know, with maybe a grandiose defense that would come out in her rages or destructiveness, like she could be so powerful as to destroy lots of things.

In this case, femininity is both desired and dangerous. While this patient enjoys the power of her more feminine self, her victory in this arena isolates her. Her brothers were attended to and she was left out. Her choice of womanliness leaves her with "no place" in either of her parents' worlds and she fears that her power will destroy those around her. Her inability to be intentional in her work seems tied to her lack of identification with either parent's power—either her mother's artistic productivity or her father's intellectual productivity. This patient

navigates the gendered terrain by creating a space between the two domains. She manages this physically by dressing in clothing that maintains a consistent and careful look while not being too feminine. This creation, like her talent, does not feel entirely internal to her.

Dr. S

Dr. S is a female analyst, who define a narcissistic disorder as an inability to see beyond one's own pain and a conflict over whether being attuned to someone else will destroy one's self. She argues that for "some people it's attached to feeling like part of a devalued group, or being unable to see oneself as valuable. For some people it's more, I think, seeing oneself as bad, and it goes with depression."

Disappointing surgeries: an unwanted female body

Dr. S describes treating a woman in three times a week for 17 years. This woman presented for treatment because she felt she always got a "raw deal" and because she was trying to figure out whether or not to have children. Dr. S explains that this woman is extremely successful with a high-powered financial job, but constantly feels undervalued and mistreated. She is condescending about her husband,

whom she married because he was handsome and came from a good family, and dismissive of others in her life.

This woman is the unwanted daughter in her family and this experience resonates powerfully through her adulthood. Dr. S explains,

> The family story was that, when she was born, her father was so disgusted that he [went to a hockey game] and didn't even bring her mother home from the hospital. He wanted a boy so much that her being a girl was totally disappointing to him.

There is cancer in the patient's family and during the treatment she found out that she had the gene associated with breast cancer and had a full mastectomy. After the surgery, it became clear that the patient had expected to feel better with a less female body. Dr. S explains,

> [When she discovered she had the cancer gene] she decided to have a mastectomy, double mastectomy, just preventatively, and she decided to have an ovarectomy, and then eventually a complete hysterectomy. Trying to remove those parts that were most vulnerable. [After each surgery,] she's always disappointed that it doesn't make her feel perfect. She expects that when she excises these parts she will now be perfect, and she never is. And really the idea [is] that she would

> be a strong, handsome man after she gets rid of the breasts and the ovaries…. [Even though she feels disappointed,] she thinks she looks better. She's only experienced her breasts as being uncomfortable excess, not pleasant. Not what she wants.

Dr. S explains that this woman hasn't been able to separate from her family. Her mother needs a great deal of bolstering and support and wishes to be enormously rich. Her father supports the family but is not hugely successful professionally, and he is seen as weak and inconsequential by his wife. Describing the patient's current relationship with her parents, Dr. S says,

> It's still about bringing home the bacon to mama. There's still a fantasy that, or there was, a fantasy that if she repaired the family by making father rich, there would be love and care and all that would come to her.

Dr. S says that the patient's symbol for receiving her father's love is that he would finally take her to a hockey game, something he has always been unwilling to do.

This woman's narcissistic issues are reflected in her experience of treatment. Dr. S describes this patient's attitude towards her by saying that she is "dismissive."

She “frequently changes appointments – too busy, can’t come. Angry that I don’t tell her what to do, how to live her life. Devaluing of what I do say most of the time.” Dr. S describes feeling like support staff, but also knowing that this woman has a fantasy that being cared about by the analyst keeps her alive. The patient’s narcissism is also core to her experience that her success is not enough, that no one appreciates her and that others are not as good as her. All of these issues mask her sense of herself as totally unworthy and unfit to be alive. Her sense that she should not exist is tied to her female-ness. If she had been born a boy, perhaps things could have been different. Perhaps, her maleness could have bolstered her weak father and saved the family, and perhaps the love she would have received if she were a boy could have made her feel whole. This woman, like some of the men described, “wins” the love of her mother over her father, but this conflicted victory is further complicated by her experience of being the “disappointing child” for having been born a girl. While these issues are part of the fabric of the treatment because of the pervasiveness of the family narrative, the associations are further embodied and strengthened when she has the surgeries and Dr. S and the patient understand the physical implications of the fantasy. The patient’s disappointment after the surgeries exposes her expectation that changing her body, excising the parts that are female

and therefore damning in terms of her father's affections, will make her feel more male and less female and therefore more perfect. All of this is, of course, complicated by the facts — the inherited risk of cancer and the very real danger of, and to, all these female parts of herself. Nevertheless, the overdetermined symbolic meaning remains strong. The parts of the patient's body that made her unlovable, the base of the original rejection and injury, are exposed as physically pathonogenic, and the patient's wish to be male and thereby lovable is made physically explicit through her response to her surgery.

Dr. M

Dr. M, a female analyst, refers to narcissism as a problem of self-esteem regulation. She describes the inflated and grandiose types and the deflated and desperate types. She argues that narcissistic characters come from narcissistic families and explains that narcissistic disorders are on a continuum of severity. She feels that she comes to know a "full scale narcissistic personality" through her countertransference. Dr. M explains,

> Across the whole spectrum, it's very hard to sit with a narcissist. But I try to take a measure of where on the continuum this is, of how severe this is, but it does take awhile for that to come forward in the

> deflated. But then I think on the axis of the down, the deflated and the grandiose – is this a person who really oscillates, or is this a person who's somewhere in the middle and sometimes shows features in both directions?

Something the matter with my vagina: uncertainty in a young woman

Dr. M tells the story of a fairly new patient, a young woman who was "supposed" to be a son in a very narcissistic family. Dr. M explains that this patient is more on the down, or deflated, side of the narcissistic spectrum. She came to treatment after dropping out of college and being unable to figure out what to do with her life. She was particularly upset because she was unsure of how she felt about her boyfriend. Dr. M explains,

> She told me that the main thing that was making her unhappy was that she just didn't know what to do about her boyfriend. She didn't know whether she loved him, or she didn't love him, or whether they should be committed to each other, or whether he loved her, or he didn't love her…. She totally had no reading on this situation with this boyfriend, and it was just making her really miserable. That's what she told me right up front. And then she told me that she had dropped out

> of college, and she hadn't been able to do anything since she did that, and she had a major panic attack when she dropped out of college, and her father had rushed forward to say, "Oh, come home," and her mother had rushed forward to say, "No, you have to stay there," and that she had precipitated a terrible fight between her parents, and she was miserable about that. And her parents didn't know what to do and she was now the problem in the family and this was horrible. But the focus was on the boyfriend, and it was, I can't love. "I don't think I know what love is," she said. And, boy, is she ever right. Is she ever correct about this. And she's so, she's almost pathologically jealous of any girl who flirts with this boy, or if he mentions another girl's name or anything like that she's immediately afraid that she's no longer center stage, that she's not winning in the great game of winning his love and all that kind of thing which is very, very typical of the deflated [narcissist].

Dr. M believes that many narcissists come from narcissistic families. Describing this women's family structure, Dr. M says,

> This particular girl was the first-born child in her family, and her father, who is the major narcissist in the family, [named her after him]. And this is typical

> of the way he behaves toward her. She's his creation, down to the details, and he interprets her problems like they're exactly like his problems…. [As for the mother,] I think the mother's more of a deflated narcissist…. [She] is long suffering, standing by her man, being there for the children, holding the whole show together, wondering whether she should get out of the marriage, but [she] can't, because look at this whole thing they have, and what would happen to the children, and so forth and so forth.
>
> She's a beautiful girl and they promote all that, but underneath it's very ambiguous. The gender identification stuff is very ambiguous…. There was a dream in which there was something the matter with her vagina…. She was terribly embarrassed to tell me about this. And I said, "What was it?" and [she said] "I just don't think I can talk about that." So I have no idea what that is, I just know we'll be back there at some point. That there's something she thinks is sexually the matter with her.

In this case there seems to be some fantasy of being the longed for son that in some way compromises the patient's femininity. This has not been fully explored yet in the treatment, but Dr. M feels that it is foreshadowed by the patient's dream that there is something wrong with her

vagina and her shamed reaction to the dream. This patient's gender confusion is embodied, but it is in the realm of the dream. Dr. M believes that, as the treatment progresses, understanding this conflict will be important in understanding the patient's issues around agency and desire.

Dr. M explains that treatment to date has focused on exploring the patient's suffering in her narcissistic family, and her inability to find her way in the world of love or achievement. The patient's focus is on being chosen and on being lovable, rather than on choosing and on loving. This is in some ways a more typically feminine position, but it is complicated because she appears to be the object of identification for her father rather than a loved other, a position that presumably takes as necessary her being masculine, if not actually having been born a boy. Her parents' responses to her failure at school speak to a complicated dynamic of attachment and identification. Her father wants her with him and/but does not push her to succeed. Her mother, in this instance, attempts to push for more separation, perhaps supporting her ability to be productive, but at the same time rejecting her.

Dr. M describes feeling "incredible pathos" for this patient, a feeling she does not experience with the more entitled, grandiose narcissistic characters she sees. Dr. M describes being with this young woman saying,

> She's not in the room. And since we've had many struggles about, "is she really going to tell me this," because if she does she becomes very dependent on me, and she can't really allow that to happen because then I'll control her and I'll repeat the problems of the narcissistic family…. She has no self, and she has the constant suspicion that everybody is going to be like her narcissistic parents. If you tell them something they immediately seize on that and they've got the answer and they tell you what to do.

The patient fears dependency because she fears being taken over, but she is also unable to be fully herself as she is so uncertain of who that person might be. This conflict resides her narcissistic family's ambivalence about separation. Dr. M describes having to find the balance of closeness in her interventions and interpretations with the patient, and with her family who attempts to intrude on the treatment through phone calls. She says she has to be careful to maintain the boundaries while not narcissistically injuring the whole unit.

Dr. L

Dr. L is a male analyst who defines narcissistic characters as those whose core issue is sustaining a fantasy of their own perfection. This ideal of perfection can have a variety of ideational contents, but it is inflated and

inflexible and is susceptible to wounds and threats by any external or internal experience that does not fit within the ideal.

Creating femininity and being chosen: a girlish woman

Dr. L presents a woman who came to treatment in conflict about whether or not to end an affair with a man who was involved with a number of different women. This patient was married and had regularly had affairs, but she had become very involved with this new man and was unsure how to proceed. Dr. L describes this patient saying,

> She is extremely involved in maintaining a narcissistically inflated image of herself as being loveable, kind, and being loved in return…. She was a very kind of feminine woman, long hair, attractive, very smart, and kind of throwing herself at me, you know…. She certainly identified as very feminine, small voice, kind of attractive, not very aggressive, seductive, but not flamboyantly seductive…. Sweet, almost little girlish quality…. It held her together. It gave her a sense of identity, it gave her a sense of self esteem. It was an inflated self-esteem, but, you know, that's quite a price. It made the world a very frightening place for her.

The patient described a very conflicted relationship with her mother who was cold, demanding and always had to be right. Her father, Dr. L explains, was largely absent, caught up in his own narcissistic defeat.

> She reported an extremely difficult experience with her mother, who's very narcissistic herself, and kind of cold, and not understanding, kind of demanding, and frightening in some ways. Kind of detached…. The mother acted like she was a know it all. She knew everything. She [the daughter] didn't know anything. If she [the daughter] had an opinion, it didn't count. Kind of bossy and controlling. [She] was terrified of the mother, scared of going against the mother, expressing any anger at the mother, disagreeing with the mother, but she wanted to separate from the mother… [She had a] sweet father, but he was really not available to her in any kind of active, genuine, loving way. He was [an artist and he would sit around in a studio and paint.] He was very narcissistic and arrogant about the fact that he was this brilliant [artist] and that somehow he had to give lessons.

Dr. L says that as a child this patient was unable to separate from her terrifying, controlling mother and so developed a false self and remained falsely connected. Her continuing narcissistic involvement in being good and

lovable is an attempt to remain in contact with her mother, but also protects her from the rage she might otherwise feel. To feel aggression is complicated on many fronts: it identifies her with her rageful mother, it might incite her mother to terrifying rage herself, and if allowed at all it might need to be turned on her absent, weak father.

Dr. L explains that this patient developed a self that was hyper-feminine, kind and good, and then over-invested in these qualities. He argues,

> If you take enormous pride, kind of narcissistic pride/ inflated pride/grandiose pride, in being a certain kind of person, then any kind of wishes, fantasies, impulses that emerge which are not in accordance with that, that are somehow not congruent with that creates enormous internal conflict and an experience of anxiety or even shame, which then has to be defended against. You know, depression, denial, rejection, externalization. You've got to get rid of it somehow. Otherwise you'd be in trouble.

Her aggression is, therefore, now threatening to her core sense of self and must be defended against.

To support her sense of herself as lovable and good, the patient turns to the external validation of being the loved object of men, and to this end she uses her

femininity. Her femininity is therefore not fully felt or experienced internally but is created in order to attract men and bolster her fragile sense of self.

Dr. L explains that he saw this patient very early on in his career and that, at the time, he did not fully understand the level of aggression in the patient and the way that her need to be seductive played out in the treatment. He reports,

> When she would feel rejected she would get enraged. And she was not aware of the degree of her rage. She couldn't allow it. So what she would do was get more demanding, and more clingy, and she became very demanding of me in the transference. You know, somehow I should reciprocate her powerful wishes to be loved and to be cared for, in terms of breaking the boundaries. She would, she wasn't this kind of "You will give me this" type. She would whine and complain and subtly consistently pressure me to break the boundaries… but it was a response, an aggressive response to her kind of whiny but very persistent demanding quality towards the things that she wanted, but in was in response to when she would feel rejected or hurt by something I would say or do, or by the parameters of the session, the fact that we were limited to twice a week for 45 minutes, and you know,

> limited to talking about things. But to try to get at her rage and anger and tenacity about trying to get me to do what she wanted to kind of take control of things was extremely difficult. She couldn't tolerate viewing herself that way. She took such pride in the kind of person she was, and would devalue of anyone else who was aggressive who was at all pushy who was at all sadistic, she just kind of looked down upon them as inferior beings….
>
> I was young…. I didn't see the aggression in it initially, and I didn't appreciate the degree to which her aggressive wishes and feelings frightened her, the amount of danger that was associated with them. I think, well, clearly, internally her vision of herself, her inflated vision of herself, was severely challenged by the reality of what she was experiencing and doing.

Dr. L also frames the termination in the context of the idealized feminine self and the underlying aggression. He says,

> Well, in the end it did not go all that well. She eventually began to pull back sessions, stopped coming for a while, and I didn't realize what was going on…. I didn't realize she was punishing me by not coming, furious at me, hoping I would miss her. I didn't

> realize that. I just thought she wasn't coming. And then she would come back… and eventually she left without getting much better.

A male actor looking for a gender

Dr. L describes seeing an older man whose fantasy of perfection was expressed in his conviction that he alone was right in love and work. He came to treatment because he felt that he had a problem with explosive anger. He was an actor, but was unable to keep jobs because he would fight with his directors. He responded to any perceived slight with rage. The man had several girlfriends, but saw each one only occasionally and fought with them frequently. Dr. L explains,

> A lot of what he told me about his early childhood was when he would get into these incredible fights with other guys, when they would say something to him on the street that devalued him in some way. He attacked them physically and he would get into brawls with them, you know. Later on it got transferred to his wives to a certain extent, but it also played out with some of his directors. It was a desperate attempt on his part to shore up his masculine identity I think, and defend against homosexuality and weakness and helplessness.

> His father was a pretty fierce guy, very demanding, kind of rigid farmer: you have to get up at five o'clock in the morning and milk the cows and I don't give a shit if the barn stinks and it's cold outside, that's what you have to do, end of the story. And the mother, I didn't get much out of him except that she was this religious fanatic.

This patient's narcissistic issues are evident in his sense of entitlement, his rage at slights and his difficulty in relationships. His parents were demanding, rigid and critical, and Dr. L explains that he developed a grandiose masculinity to defend against longing and need. Dr. L reports,

> With him he was bolstering up his male strength and defending against the feelings of homosexuality, whatever passive yearnings were there. But that was definitely more gender. He was looking for a gender, an image of a specific kind of male figure, but he needed to defend against other parts of himself, give him a sense of cohesion and identity and power and strength.

For this man, the gender ambivalence was about the need to be a certain kind of man — a tough, untouchable masculine figure and this issue lead to the termination of the

treatment. This patient left treatment because he could not tolerate the analyst's vacation.

> Yeah, he left before my vacation. He wouldn't come back after my vacation. And I didn't sense it coming. There were some clues, but I didn't pick up on them, but part of it could be my countertransference because he was so impossible to work with that maybe part of me didn't want him to come back. You know.
>
> It was interesting because, let me tell you, you wouldn't have a clue that you mattered at all to this guy. But underneath, underneath the narcissistic defenses you can see these powerful longings, these fears. He would just keep me away from him, and he was lost in his own thoughts…. You couldn't enter into his world at all.

In this case the subject found the patient extremely difficult to sit with because he seemed so unrelated and impenetrable in the room. The subject feels that perhaps he missed some of the "clues" of dependency in the treatment because of this difficulty.

<u>The perfectionist: a tough guy's denial</u>

Dr. L presents another man whom he describes as a perfectionist. This patient came to treatment because he

could not keep a job. He was always critical of those he worked with and could not stand being given corrections at work. Dr. L explains that the man's father was a weak man who had been successful and wealthy but had lost everything and his mother was very critical. This treatment is ongoing and Dr. L explains,

> Now, it's a struggle because he is so in conflict with his need to identify with this kind of grandiose, inflated notion of his strength and power, and his ability to do it on his own. To not need anyone, to prove to himself and to his father that he's not this little schleppy guy who can't do anything, that he's really a tough guy.

In this case, the patient has developed a grandiose masculinity that is destructive to him professionally. He feels that he cannot have any weakness because of his need to disidentify with his father's failures and defend against his critical mother. His own criticism of others may also be an identification with his mother which might also complicate his attempt to perfect his masculine façade. This patient struggles to need no one, to be all-powerful, to be a "tough guy."

Dr. L says he worries about this patient's self-destructiveness. He worries the patient will lose his job

and be unable to support himself. Treatment is helping him to be more modulated, but it is also difficult due in part to the patient's conflict around dependency.

> There's something about the father also in his resistance to the treatment. It's not just this longing, but also this fear of being controlled and bossed around. He wants to separate himself from the father.

Dr. L believes that finding a way to break down the masculine perfection and allow for some of the more feminine longing, the wish for care, will prove to be important in helping this patient. He hopes to eventually be able to address issues of dependency in this treatment.

Dr. P

Dr. P is a female analyst who defines narcissism as a lack of a stable sense of self. She explains that narcissists "can be easily rocked in terms of who they are," and that any slight (perceived or real) is a humiliation and an assault on the self, which can lead to retreat or rage. She says, "What you have there are people who are just felled. You know, they're knocked over by a little breeze. Not even a major wind." Dr. P argues that for most people with narcissistic disorders there is a particular area in

which they are most vulnerable, the body or work or intellectual prowess, and that there is a developmental reason why that particular area of the self has become vulnerable.

Clothes make the woman: a people pleaser

Dr. P describes a woman who came to treatment because of she felt out of control, unable to curb her spending and unable to say no to the demands of her extended family. This woman was preoccupied with her weight and her clothes. Her physical preoccupations were not explicitly gendered but her focus was on being a certain kind of woman: thin and chic and also very giving. Dr. P says, "usually when there's a problem like this, they can't really respect themselves as women either." Because, Dr. P explains, real women have breasts and hips; to fit into the right clothes and fit the hyper-slender ideal body image, women must remove those female parts. Dr. P explains that this patient is "skin and bones," and she costumes herself in perfect clothing.

> She is somebody who's 5'5" and weighs 104 pounds. And she is terrified of gaining weight. She is like skin and bones. She's extremely chic. She buys, she has just like thousands [of clothes]. And yet she will say, "I don't go anywhere. I don't need so many

clothes." She also can't decide what to wear or what to pick. But there's an inner need to look perfect.

This patient's narcissistic issues are evident in her over-valuation of how she is seen; she views her image as central to her identity and clothes become an important part of that presentation. This woman struggles because she cannot not have the clothes. Dr. P says, "Nothing gives her pleasure. Her clothes don't give her pleasure because she's guilty about buying them, and she is not happy." But the need to look perfect drives her. She seems to need to feed her idealized feminine self with the right accessories, to make up for her lack of self with material objects, and she is unable not to buy things. Her need to be seen a certain way overwhelms any sense of her own desire and she is tortured because she has no sense of what she herself wants to wear. Dr. P explains that this woman says, "I wouldn't want to think anyone was saying 'she gained weight'." Although the need to look perfect is experienced as her own, it is not actually her own experience of her body that matters, but the external, social view of her body.

Paralleling her idea of the perfect body, Dr. P reports, this woman has an idea of the perfect woman/wife/mother, and she strives to fit that image and cannot allow for feelings that threaten that sense of herself. Dr. P explains, "the aggression [is] just so

muted you just don't get it. She prizes herself for being a nice person, a good person." Women like her, Dr. P reports, focus on

> keeping the energies away from [their] own needs. I want to say, "where are you in this picture? What do you need?" All or their energies are going outward rather than being of focused on themselves.

Dr. P reports that this woman had a depressed mother, a father who did not attend to her and an envious younger sister.

> The mother was kind of just a nervous woman. She also had a sister, a very envious younger sister who became a real problem, so she kind of just got left out. But the mother was just kind of an anxious person who was depressed when she was little, and basically someone who's not really tuned into to you, and the father worked. The father must have had a girlfriend, that's my conclusion, but the father was never home. So the mother was just kind of low key and unhappy and just around the house.

Dr. P describes the treatment with this patient as a chance for the patient to be seen. She says,

> She'll come in and preen. She stands before me and, I mean, that's part of the treatment, I think, is to come

> in and show me what she's wearing and she'll walk in the door and say, "Oh, I wore these boots because it was raining today." There's no barrier. She doesn't wait to get into the office, so there's an awful lot of showing me. Showing me the pocketbook; there's a different $1,500 pocketbook walking in every time she comes.
>
> [When she came to treatment,] I knew just where to, how to speak to her. "So how many black sweaters do you have and where are they? How many do you have in your country house? How many do you have in the beach house? And when you put them on what do you see? What is it like for you? How many are you going to pack?" Very, very concrete things. And then she just kind of lifts herself out of it and all of the sudden you hear a whole other, you know, "I realize I don't have enough space to think…."

Dr. P explains that women like this patient usually have parents who were not attuned to them and so they have never really been seen. By meeting this patient on the level of the concrete, seeing her clothes and her female self, Dr. P is able to help her to be more related and move to a less concrete place.

While the focus for this patient is purportedly outward, Dr. P notes through the transference that there is

really no connection to the other. Dr. P experiences the patient's narcissistic lack of awareness in the realm of the body. Dr. P recalls the patient panicking about gaining weight.

> Yeah, like going to 106, 107. And of course she's saying this in front of me and I certainly am no skinny. I mean, there's such a lack of awareness of the therapist and the therapist's body. It's a very interesting phenomenon.

Dr. P frames this as a lack of awareness of the therapist, but it may also be an act of aggression towards the therapist. It may therefore be a disconnect in the transference, but it is also possible that since the aggression is intolerable, rather than express it affectively, it is enacted through a commentary on the physical body.

In this chapter, I have discussed the expressions of gender conflict in thirteen patients with narcissistic pathology as they were presented to me by the patients' psychoanalysts. In the following chapter I will discuss the similarities and differences in the patients' experiences of narcissism and gender and explore the relationship between these experiences and gendered family dynamics.

Chapter Five: Thematic Analysis

In this chapter I will explore the relationship between the expression of internal gender conflict and the specifics of a gendered experience of family dynamics as both relate to the development and expression of a narcissistic disorder. Although the sample is small, certain patterns can be identified. These patients have narcissistic disorders and experience significant gender ambivalence. The conflicts about gender, conscious or unconscious, were experienced either in feelings about the body or in idealizations of masculinity or femininity that were expressed in relation to the other. Juxtaposing the patients' family dynamics, as they are understood in their analyses, with the different expressions of gender conflict suggests a possible association between them and patterns of parental involvement. I will review the case material presented in the last chapter to explicate these patterns.

A narcissistic experience of gender

As the cases in the previous chapter illustrate, there exists for both men and women a complex relationship between narcissistic pathology and the experience of gender. It is expressed as a struggle about the very idea of being male or female as it relates to their experience of their bodies and their relationships with other people. From the sample, I

identified four different experiences of this gender conflict: men who feel female, women who experience their bodies as faulty or damaged, women who experience themselves as objects, and men who present as hyper-masculine to defend against dependency and feminine longing. In the first two groups, the focus of the gender struggle is in the physical body, whereas in the second two groups the focus is on a conceptualization, an idea of what it means to be male or female, that emerges in relationship to other people in the patients' lives and especially in the transference. The distinction between these two types of expression is not rigid, as the body is often at issue in cases where the transference is more prominent, and the transference relationship is certainly important in the cases in which the body is more prominent. There are also patients who employ their bodies as tools for connecting to other people, and in these cases the body is central only as it serves to engage others. However, the distinction between the concrete focus on the body and the conceptual experience is useful for exploring different ways that these gender conflicts might be expressed in patients with narcissistic pathology and channels through which it may become known in the treatment.

Struggle expressed in conflict about the physical, gendered body

For the set of patients whose gender struggle manifests itself in the realm of the physical body, there is a sense that there is something wrong with that body. The men in this group have a sense of themselves as damaged men, and also as female. The women feel there is something wrong with, damaged and undesirable about their female organs, but they do not feel explicitly male.

Men who feel female

Three of the narcissistic men presented experience themselves in some physical way as female. These men are heterosexual and outwardly masculine, but they have a fear or fantasy that they are women. These appear to be the most disturbed of the patients presented. They each have some symptoms that sound delusional or psychotic, but their analysts did not experience them as truly psychotic and believed their symptoms to be largely due to narcissistic pathology. Each of these patients was able to engage in a three to four times a week analytic treatment, and, their analysts believe, was greatly helped by the treatment. This group includes Dr. T's patient who fears he is physically losing his masculine features and becoming a woman, Dr. A's patient with gender confusion whose mother prays for his protection by saying he is a girl, and Dr. J's patient who

feels he should have been born a woman.

The man who believes he is turning into a woman comes to treatment because he believes that his body is physically changing, although his engagement with analysis suggests that he has some idea that this is a psychological issue. His conflict with being a man is expressed in his physical body — the fear and fantasy that he is becoming a woman. His physical preoccupations are understood as a way of hovering over his own body as his mother hovered over him, as if he were both a woman and his own baby.

The man with gender confusion struggles with his physical maleness and has “terrible feelings about his penis.” This patient’s ambivalence seems tied to his mother’s “protection” which is made explicit in the prayer of “do not take this child, it is a girl.” To be protected is to be female, like the mother, but being male is more desirable. This patient’s ambivalence is manifested physically in his sense of his beauty as like his mother’s, and his feeling that there is something wrong with his male body. Another element of this patient’s feminine identification is connected to his idea of female “goodness”: he feels he must be kind and good, and he is unable to tolerate/know his own rage and aggression. This patient remains connected to the male with grandiose, masculine fantasies about being the president or being an astronaut.

The man who feels he “should have been born a woman” and would like to be a woman idealizes women and believes men are nothing. Whether this is primarily an embodied desire is not clear, but his experience seems similar to the other two men in terms of his over-identification with the feminine. The subject remarks that “looking at him you could never have told [that he feels female]” implying that there is a physical component that is not acted on but is felt.

Women who feel faulty

Two of the women presented experience their physical femaleness as defective. Their experience is one of being female with “something wrong.” This experience of defect is part of the larger narcissistic struggle of not being good enough. This group includes Dr. J’s patient who cannot imagine how a baby could come out of her body, and Dr. S’s patient who is disappointed by her surgeries after discovering she has the gene that predisposes her to cancer. It may that Dr. M’s patient who has a dream that there is something wrong with her vagina should be in this group as well, but I have not included her because the specifics of her embodied conflict are not yet known.

The woman who is unable to conceive of a baby coming out of her body has no question about her femaleness in other areas, but her conflict is embodied in her inability

to imagine her own physical capacity to give birth. This woman has been "indiscriminately sexual" and has always "had boyfriends." She uses her sexuality to have relationships, but her experience of her body is disconnected and she questions her ability to give birth. She is unable to imagine a characteristic female capacity of her body — the ability to have a baby. Dr. J describes her as ungendered and says that her ability to eventually carry and give birth to a child was part of becoming gendered through the treatment.

The woman who underwent extensive surgery for cancer prophylaxis had been rejected by her father because she is female, and this experience of rejection is expressed in her sense of her body. She is able to accept her more masculine power and aggression and be tremendously successful in a largely male field, but femininity is more difficult for her. When this woman discovers that she has the gene associated with a high risk for cancer she chooses to have surgery to remove her breasts and her internal female organs. She does not imagine getting rid of these parts of herself as a loss, and is disappointed that she does not feel more perfect after surgery. Through this disappointment, she becomes aware of her fantasy that if her body were male (and not female) she would be loved by her father. This woman knows that she was the disappointing child because she was a girl and this is expressed in

feelings about her female body.

Engendering the self for and through the other

The patients in this set are men and women who have a conflicted experience of gender that is based in the idea of being a certain kind of man or woman, an ego ideal, rather than a sense of being or wanting to be the opposite gender. These patients share a need to gender themselves for the other. This group illustrates more clearly the distinction between a more grandiose masculine narcissism and a more needy/performative feminine narcissism. The men in this group struggle to find male figures with whom to identify and feel the need to perform the role of male; they are not able to integrate different parts of themselves. They develop a grandiose masculinity based in a denial of dependency, a fantasy of "tough guy" self-containment. Dr. A explains that dominance can develop in boys as a compensation for the terrifying realization of difference from the mother. She says,

> I think there is something about the boy's sense of difference from the mother and what he makes of that, you know, the power of the mother. I guess, like Chasseguet-Smirgel's idea of the omnipotent mother, that there is this deep narcissistic wound that then gets tied to castration anxiety and compensation for

> that by then being dominating or dominant. That is one way that the sexual difference gets worked out by the boys. But there is this kind of terror that they're not the same as the mother.

The women in this group also lack a fully felt experience of themselves as female. Their bodies are experienced as objects rather than subjects, and they tend to use a constructed femininity in order to receive attention, but do not feel pleasure or agency. For many of these women there is also an overinvestment in being "good" that is again related to pleasing other people.

A number of subjects comment that narcissistic men tend to be more grandiose and dominating and women tend to be more "down." Dr. L explains this difference partly as one of expectation:

> There's so much emphasis on boys being aggressive and being strong, being competitive. And I think that the grandiosity is kind of shaped in that direction because of the pressures being put on them. There's a lot of pressure on women to be nice and sweet and gentle and caring and empathic. But certainly there's a lot of emphasis on you know, you've got to go out there and kick ass, for boys. It tends to move it in a direction of more kind of aggressive, expansive, phallic kind of narcissism.

The cases in this section support this gender distinction in the expression and pathology of narcissism, providing examples men who create hyper-masculine, harsh exteriors to fend off more feminine wishes/longings, and women who do not feel pleasure and/or agency in their experience of femaleness, but perform femininity for the approval of others.

For all these patients, the gender conflict becomes evident in the ways they navigate their relationships, and the specific issues are largely understood through the transference in five of the seven cases that follow.

Men in search of a masculinity

This group consists of narcissistic men who fend off dependency needs with grandiose masculinity. These men have harsh, punishing super-egos. They believe that men are a certain way, and they strive to be tough and self-sufficient to fill that role. The expression of these traits is so extreme that they become self-destructive. While their self-destructiveness may also be a result of the conflict around gender, these patients' "feminine wishes," become known through the transference. In the treatment they search for identification and struggle with dependency. This group includes Dr. L's angry actor who leaves treatment because he cannot tolerate dependency, Dr. L's perfectionist who cannot

keep a job, and Dr. T's patient who is excited to be loved for his smelly armpits and disappointed by his analyst's duffel coat.

The angry man who leaves treatment has an overinvestment in being the hard, independent man who needs no one in order to defend against his longing. Dr. L describes this man's grandiosity and anger as a "desperate attempt to shore up his masculine identity." His more feminine wishes were never attended to or allowed and he has created a rigid masculinity that must be protected. When the dependency begins to develop in the treatment and the patient feels the loss of the analyst, the dependency or the loss is intolerable and he has to leave treatment.

The perfectionist struggles to maintain/live up to the grandiose masculine idea of himself he has created. In this idea of himself there is no room for weakness or dependency. This man's gender conflict is evident in his rigid masculine ideal of self-sufficiency, developed in response to his weak father, and his inability to integrate parts of himself that do not fit this ideal. This idea of himself is unattainable and destructive to his work and his relationships, but he feels it must be maintained. His wish to be cared for and the conflict he feels about this wish are understood only through the transference.

The man who is surprised and excited by the idea of a woman who can love his masculine smell struggles with his

sense of himself as a man and searches for masculine figures with whom to identify. This man struggles to find a comfortable masculinity. He was an effeminate child who is interested in the bodies of hyper-masculine men. He looks to the analyst to find a model of masculinity and is upset when this identification is disrupted. This man's conflict about his maleness is evident in his response to having a woman love his smelly armpits — he is surprised, suggesting some confusion about his appeal as a man and excitement at being accepted/wanted as a man.

Women whose femininity is performed but not felt

The women in this group express their gender struggles in their lack of pleasure in their bodies and their objectification of themselves for other people in their lives. These women perform an ideal femininity rather than experiencing and expressing something authentic in which they feel alive. They are focused on the other, their audience, and need to be seen as a certain kind of woman. Dr. P explains that for these women, it is a matter of

> keeping the energies away from one's own needs; it's like I want to say, where are you in this picture? What do you need? All or their energies are going outward rather than being of focused on themselves. [This is] much more female. Much more female.

For some this outward ideal of womanhood is constructed through clothes and thinness, for others it is through kindness and doing for others and for still others it is the act of being chosen. Being an object of someone else's desire (being chosen) rather than the subject of one's own desire (choosing) is an issue many of these women and is tied to an idea of a passive feminine role. These women construct femininity as part of a larger narcissistic ego-ideal. They then use this constructed femininity to gain approval and feel sustained, but they do not experience an authentic femininity (which also might be used with other people). These constructions, however, require great effort and are fragile, and these women are easily threatened by any feeling or experience that does not fit within their ideal.

This group includes: Dr P's patient who cannot tolerate having been seen as having gained weight, Dr. A's patient who uses clothes to sustain a consistent self, Dr. L's girlish patient who cannot feel aggression, Dr. T's patient who was experiences her own body as a visual object, and Dr. M's patient who is unable to discuss a dream in which there is something wrong with her vagina.

The thin woman who is plagued by concerns about what others think of her does not feel pleasure in her femininity. She is consumed by the need to be thin and to

please other people and feels she is unable to make space for herself in her life. Her struggle is played out on her body. Her analyst suggests that her need to be so thin is a denial of femininity on some level, but I have chosen to put her in this group rather than the first group because so much of her struggle is her focus on the other: how she appears to others rather than how she feels in her body. The gendered element of this woman's struggle is manifested in her need to be a fantasized feminine ideal in all areas — to have a perfect body, to wear perfect clothes, to be a perfect mother, to feel perfect goodness — rather than being able to determine what her experience of being female is for herself. There is no place in this ideal for authentic pleasure or for aggression and so she suffers, afraid that she will be seen as (rather than feel) other than perfect.

The woman who attempts to use her clothes to maintain a consistent self struggles with her sense of femininity as she desires and is terrified of her female power. Her feelings about her body express her dilemma. She enjoys her body which is more female than her mother's, but she attacks it when she is upset. This woman needs to present her body very carefully to others as though it cannot be trusted or is not real in some way. Similarly, the struggle to work is gendered, as in her family artistic creativity is the domain of her mother and intellectual productivity is the purview of her father. She navigates this conflict by feeling that

her work can come to her, but she cannot intentionally produce.

The woman who has a “girlish quality” struggles because she is over-invested in being kind and good and cannot tolerate her own aggression. Her gender conflict is expressed in her need to live up to an ideal of femininity that demands passivity and pure goodness, and that ideal requires that she be chosen. This patient’s identity is tied to her girlishness, and this deprives her of agency and power. Her role as a loved object for men rather than the subject of her own desire plays out in the transference and she feels (unacknowledged) rage at the boundaries of the treatment which she perceives as rejections.

The woman who was photographed as child experiences her body as a visual object for others. She struggles with intentional creativity and does not feel pleasure. In this woman’s family, her father is creative, but his creative production objectifies her body. She has come to see her own body as an object and uses it to attract men. Her femininity itself is for show. She wants to be loved and is promiscuously sexual, but she does not feel pleasure. The transference reveals the conflict that she feels about wanting and being wanted. By exploring this dynamic in treatment, she is able in her work to produce a pornographic book. This woman is able to find an experience of herself as both object and subject and is then able to move forward.

The woman who dreams that there is something wrong with her vagina expresses her gender ambivalence in her issues with work and her anxieties in her relationship with her boyfriend. She questions whether is allowed ambition and cannot identify her own feelings about other people. She feels that she must be chosen and this feeling overwhelms any experience she might have of wanting to choose. This woman had a dream that there was something wrong with her vagina, and though she finds her dream too difficult to discuss, her analyst believes that she has an experience of her female body as defective and that that experience will prove to be core to her other gender struggles.

Development of the gender struggle: The families

In this section I will discuss the patterns of family dynamics that emerged in the material and outline possible relationships between the presentation of gender ambivalence and family dynamics. Dr. J posits that narcissistic disorders stem from "some kind of inadequate parenting. Inadequate reflection, inadequate mirroring… or alternatively some kind of trauma." An investigation of these patients' families (as they were understood in their analyses) reveals three primary ways that this "inadequacy" occurs: intrusion, rejection/criticism and neglect. There are, of course, many ways to view a family but I have grouped these cases using the primary dynamics that seem

most relevant to the gender conflict. For each of these dynamics, the specific combination of mother or father and son or daughter appears to be relevant to the development of the specific struggle in the arena of gender.

Intrusive mother, absent father, boy child

This group consists of men who report having intrusive mothers and absent fathers and who all feel female in some way. The four men in this group are Dr. T's patient who believes he is turning into a woman, Dr. J's patient who feels like a woman, Dr. A's patient who feels he should have been born a woman and Dr. T's patient who is surprised to be loved for his smell. Each of these men describes having been the special son on whom his mother doted, the Oedipal victor over a weak or absent father.

These men share the boyhood experience of an overwhelming, intrusive mother and an adult ambivalence about their embodied maleness. Dr T states that his patient who believes he is turning into a woman had a mother who was terrified that any independence would lead to physical harm. She hovered over her son. "Becoming a woman" allows this man to stay connected to his mother and to fend off her rage at separation. Dr. J's patient who feels he is a woman describes a mother who is "intensely involved with the patient" and a father who is a "washed up thing." In this case, the mother's feelings are constantly changing, and so

to stay close to her requires merger: any separation threatens total abandonment. Dr. A's patient who believes he should have been born a woman had a mother who invaded her son physically, giving him painful enemas. "Being a woman" keeps this man connected to his mother and also allows him the protection offered by her prayer: by being female, like her, he remains safe. Dr. T reports that his patient who questions his physical maleness and is surprised at being loved for his masculine smell has an "exquisitely intrusive" mother.

In each of these cases, the mother was intrusive, overwhelming and afraid of separation. For each of these boys, the mother's inability to tolerate difference made separation impossible without great threat. The failure of separation combined with an over-identification with the mother plays out in adulthood as they experience themselves as not male and/or female. Dr. T comments that,

> masculinity is harder to come by than femininity, which Freud related to the fact that the first relationship is with the mother, so the boy has a harder time than the girl. Because the boy has to change his identification.

In these cases, the switch in identification has not occurred; these men continue to be identified with their mothers and are therefore left to struggle with feeling they

are men and not men even on a physical level. This failure to separate is also core to their narcissism, as the process of separation is necessary for the integration of the ego and the development of the self.

Intrusive mother, absent father, girl child

Dr. J's female patient who is unable to imagine giving birth also reports having an intrusive mother and an absent father. She struggles to experience herself as an adult woman physically. Dr. J describes his patient's mother as "nutty" and explains that she used to sleep naked in bed with the patient and show her where she came out of. As an adult, the patient cannot imagine that she has the ability to physically reproduce, to use her body in the way that was inappropriately demonstrated to her nightly. She experiences a separation from that part of herself that was the inverse of the specific way her mother had intruded. Dr. T posits,

> "the intrusiveness [of the mother] in women gets reflected [in] the competition between mother and daughter. Either to compete with her to an extreme degree, or not to compete with her to an extreme degree.

This woman opts out of the competition by being "ungendered." Unlike the men, she cannot identify with her

mother fully because she is female, there is no intrinsic differentiation, and therefore the identification is too competitive and too threatening.

Narcissistic father, untouchable mother and girl child

This group includes the women whose fathers are grandiose and narcissistic and who are unable, for different reasons, to compete with their mothers. Three of the women in this set have stories that revolve around their relationships to their fathers and a fourth woman who also describes having a narcissistic father has a controlling and terrifying mother who is more central to her story. Although the specific family dynamics in each situation are different, I have classified these women together because there seems to be something significant in the relationship of these fathers and daughters. Dr. M suggests that many narcissistic women have narcissistic fathers and that these fathers tend to be absent and overbearing at the same time. She says,

> the fathers tend to on the one hand be very remote and unavailable because they're off doing their grandiose thing, often very successfully, so they're off flying their airplanes and doing this kind of thing. But then when they are there, they're very micromanaging. And that contrast between the unavailability on the one hand and the over-involvement on the other hand is so

> typical of women with narcissistic problems who had a narcissistic grandiose father, and that is, to my mind, most of them.

The women in this group include: Dr. M's patient who is her father's creation, Dr. T's patient whose father photographed her naked for his art, Dr. L's girlish patient who leaves treatment because she cannot tolerate the boundaries, and Dr. S's patient's whose father rejected her because she was a girl. I have chosen to include the last woman in this set even though her narrative does not explicitly describe her father's pathology because her absented father is so central to her narrative, and because his need for a boy child and his response to her birth suggest significant narcissistic issues. These women share the experience of a narcissistic father, but the other elements of the structure of their family are significantly different and seem to affect their issues of gender struggle.

Two of the women have grandiose, intrusive fathers and mothers who are shadowy and depressed. These women struggle with their own subjectivity and find it difficult to know what they want. Dr. M describes her patient as "her father's creation." The father is a narcissist who expects and demands that his daughter (who was supposed to be a son) be just like him. This father cannot imagine or tolerate his child's separateness/difference from him. She is unable

to know her own feelings — does she love her boyfriend? — or exert agency in her life. This woman also struggles on the level of her body.

Dr. T's patient's father took photographic portraits of her nude as a child and displayed the photographs in the house. He is also unable to see his daughter as separate and in a different way makes her his creation, as he recreates her for and in his art. She, too, struggles with agency and the capacity to create, and also seems invested in being the object for others rather than embracing her own subjective experience. For both of these women, competing with their mothers and/or identifying with their mothers is difficult because to some degree they have been chosen by their fathers over their mothers, and they fear their mothers' envy.

Dr. L' patient who is "girlish" and struggles with choices in her relationship has a father who is absent because of his narcissistic defeat and a mother who is terrifying and does not tolerate separateness. The patient is focused on seducing and does not experience her own pleasure. She remains "girlish," passive and immature, to avoid engaging with the terror of adult separation from her mother.

Dr. S's patient's family story is that her father rejected her because she was a girl and therefore not like him. The father was not successful, but he was nonetheless

the arbiter of value in the family and having a daughter instead of a son was intolerable. The patient makes money for her parents. She attempts to make-up for/ bolster her father with the hopes of gaining love, but in this way she actually becomes her mother's partner, overtaking her father even as she longs for his attention and approval. Dr. S says that this woman has not been able to separate from this dynamic and remains focused on this struggle that has gender bias at its core. For this woman, the ambivalence about her own femaleness is manifested in her experience that she has always gotten a raw deal and her feelings about her female body.

Critical parent, boy child

This group consists of two men who describe harsh critical parents and struggle to prove their masculinity. It includes Dr. L's angry male patient whose father was critical and whose mother was rigid and unavailable, and Dr. L's perfectionist patient whose mother was very critical. Both of these men identify with the critical parent while attempting to defend against the feeling of being criticized and rejected. They feel they must defend against longing and bolster an inauthentic hyper-masculinity. In each of these cases issues of dependence and identification become evident in the transference.

Neglectful/ absent mother and father, girl child

These women describe feeling left out of their families — neglected and unseen. In this group are Dr. P's patient who is unable to say no to anyone and is terrified she will be perceived as having gained weight, and Dr. A's patient for whom clothes are vital to her sense of herself.

As adults, these women, who were not seen/known as children, are focused on presentation. They are overly-invested in the opinion of the other and have difficulty holding onto their own experience. Dr. P's patient's mother was anxious and depressed and her father was "never home," so the patient "just got left out." The lack of attunement in this case leaves the woman without an internal sense of herself and she creates a female role that she plays and worries about being seen. Dr. A's patient feels there is no place for her in her family. She feels rejected, isolated and unknown. She too creates a fragile persona with which to navigate the world and worries constantly about having her experience overwhelmed and being exposed.

The gendered struggle and the family structure

As I've reviewed the relationship of different family structures to the gender conflicts of patients with narcissistic disorders, certain associations have emerged. Because the sample is small, it is not possible to draw

conclusions, but the associations suggest interesting possibilities for further exploration. In this sample, those patients who struggle with the embodied self, with how they experience their physical body as gendered, tended to have intrusive parents (four out of five); those patients whose parents were more critical or absent tended to manifest their struggles in the quality of their relatedness, emphasizing ideals of masculinity and femininity and focusing on how others perceive them (five out of six). Particularly striking are two associations: the narcissistic men in this sample who had intrusive mothers feel themselves to be female in some way, and the women who were neglected and left out by their parents, become overly-invested in being seen and develop an external, superficial, construction of femininity.

In the next chapter, I will explore further the possible relationships between gender conflicts, gendered resolution of family struggles, and specific presentations of narcissistic pathology, and draw on analytic theory to illuminate these complex knots of experiences, influences and outcomes.

Chapter Six: Discussion

In this chapter I will discuss my findings on narcissistic presentation, gender conflict and family dynamics, explore the interplay between the three, and integrate the results into the theoretical literature. I will argue that there is an experience of gender conflict in many patients with narcissistic pathology. I will suggest that this narcissistic gender conflict may be experienced as a struggle with feelings about the physical body or as a struggle with an ideal of masculinity or femininity, which is frequently experienced in relation to others and understood in the treatment through the transference. I will discuss each of these expressions of conflict and how they relate to expressions of narcissistic pathology and patterns of early identification. I will contextualize these findings in my observations about patterns of parental involvement. I will also discuss the limitations of this study and present possible areas for future research.

Narcissistic presentation

I chose the seven analysts I interviewed for this study because of their clinical experience and expertise. All of the subjects have published on narcissism and/or gender. It was interesting to me that the male analysts I interviewed all commented that they did not think of themselves as

thinking about gender. As they spoke to me, they clearly had thoughts about gendered experience, but it was not a frame they articulated. The female analysts reported that they were conscious of gender issues in their clinical thinking.

The analysts described a range of transference and countertransference experiences with the patients with narcissistic pathology they chose to present. They reported idealizing transferences in more depressed patients and dismissive attitudes in more entitled patients, but they also discussed chaotic transference dynamics and shifts over time. Patterns of transference dynamics seem most connected to gender and narcissistic presentation and I will discuss these patterns as they emerge in the results.

When asked to define narcissistic pathology, the analysts produced their own largely phenomenological definitions that were based in their theoretical orientations, but privileged their clinical experiences. I did not ask them to evaluate their patients using formal psychiatric diagnostic criteria, and they did not appear to rely on those criteria diagnostically or use specific abstract concepts to describe their patients' pathologies.

The patients in this study were identified by their analysts as having narcissistic pathology because they have poorly integrated selves, rigid ideals and compromised object relations; these people cannot tolerate the

limitations of life and are easily internally injured. Within this basic framework, however, the patients' symptoms, struggles and level of functioning vary tremendously. They may be grandiose or depleted, excessively angry or unreasonably sweet. Some are so invested in themselves that they do not experience other people as separate individuals, and some are so focused on others for regulation that they cannot experience themselves as central to their own lives. Some are successful in work, while others struggle to keep jobs. At least two of the women seem to have a level of organization approaching the neurotic, while two of the men have symptoms that could be classified as delusional. With these differences all of these patients are understood by their analysts to have significant narcissistic pathology.

The patients entered analysis for many different reasons. According to the analysts, the men came to treatment with issues including a physical experience of turning into a woman, a lack of self-constancy, an inability to have sexual relationships, uncontrollable rage, dissatisfaction in an intimate relationship, and the inability to succeed at work. The women presented with issues that included: an inability to move forward with work, a lack of pleasure, an inability to make decisions, a feeling of being constantly mistreated, an experience of extreme shame, difficulty saying no to other people, and

being overwhelmed by the feelings and thoughts of others.

These varied symptoms and presenting difficulties suggest that the patients range in level of organization from neurotic to borderline. Although narcissistic characters may fall between neurotic and borderline levels of organization because they have a more stable (albeit pathological) sense of self than people organized at a borderline level, they lack the internal integration and the capacity for full object relations necessary to be truly neurotic; within this space between the neurotic and the borderline there appear to be a range of development in terms of ego identity and object relations (Bursten, 1973; Kernberg, 1984). The woman who experiences her body as a visual object, the woman who is disappointed after surgical removal of her female organs to prevent cancer, the girlish woman and the female people pleaser appear to be organized at a higher level. In contrast, the men with embodiment issues — the man who believes he is turning into a woman, the man with poor self-constancy and the man who has “gender confusion” — seem to be organized at a lower level. It seems likely that the men’s experience of alterations in reality testing, their experience of being in some way female, is related to this more borderline level of organization. I will explore this relationship further later in this chapter.

Gender conflict in patients with narcissistic pathology

As discussed in chapter five, the central finding in this study is that the experience of gender itself is conflicted for many patients with narcissistic disorders in ways that specifically articulate with their narcissism. These patients struggle with the experience of being male or being female. This phenomenon was reported by analysts of different theoretical orientations, across a group of patients with a variety of narcissistic presentations, and emerged even though analysts were not asked specifically to discuss patients with gender issues.

In discussing the patients' experiences of gender I have struggled with language. I have tried to describe the issues as they are understood by the analysts rather than label them. It is, however, important to make the distinction between this group of patients and people who are transgendered, those who fully experience their anatomical sex as ego-dystonic. Only one of the patients discussed came to treatment with a complaint about gender (he feared he was turning into a woman) and none of the patients presented with specific issues of gender identity. However, in each case there is some fragility or conflict in the experience of gender that comes to light in the treatment.

From the sample, I identified two significant expressions of this gender ambivalence: struggles in the

physical body, and interpersonal struggles based in an ideal version of what it means to be male or female. The first involves a physical sense of oneself as not fully or adequately male or female. For the men in this group, the experience is of being female. For the women, the experience is of being faulty or damaged women. I will at times refer to this group as the group with embodiment issues because for these people the experience of gender conflict is articulated as a conflicted experience of their physical, gendered bodies. The second expression tends to manifest itself in relation to others and involves idealized versions of masculinity and femininity. At times I will refer to this group as the group with conflict about gender ideals or the group who experiences gender conflict in relation to others. In both groups the struggles include gendered issues of subjectivity, power, aggression, dependency and creativity.

Although most of the analysts did not discuss their patients' presentation in terms of the poles of narcissistic disturbance, the patients can be located on a continuum ranging from the overt/ entitled/ grandiose side of the spectrum to the covert/ depleted/ depressed side. Those on the more overt side include the male actor, the male perfectionist, the man whose mother prayed for him, and the successful woman who feels she gets a raw deal. Those patients whose narcissism is expressed more overtly include

the woman who dreams there is something wrong with her vagina, the woman who feels she is always being watched, the girlish woman, the woman who feels the need to please everyone, the man who is disappointed by his analyst's duffel coat, and the man who has no sense of constancy. It is not clear where on this continuum fall the man who believes he is turning into a woman, the woman who can't imagine giving birth or the woman who experiences her body as a visual object.

It is interesting that most of the analysts did not discuss their patients in terms of the overt or covert presentation and that this distinction was not useful in determining level of disturbance. Analysts focused on the specific experience rather than a diagnostic label. Some did reflect of the grandiosity or the deflated aspects of their patients, but did not use theory to discuss these aspects. Some clinicians now suggest that the covert narcissists are more disturbed. Dr. J suggests that, "deflated narcissists are kind of less well defended. They just feel bad about what happened to them." While there is a more depressed element to those patients in the sample with covert narcissistic pathology, they are not more disturbed. However, if an overt narcissist successfully defends and has no conflict about their inflated sense-of-self, he or she will not present for treatment. It is possible, therefore, that since all of the patients entered

analysis, there exists a certain level of suffering in all the patients in this study and so there is no clear distinction between the level of disturbance in the overt and the covert. While the overt/covert presentation did not signify level of disturbance, it was interesting in terms of its relationship to gender presentation, narcissistic expression and transference/ countertransference dynamics.

Gender and narcissistic expression

There is no simple gender divide on the continuum of narcissistic expression, but there is, for this small sample, a suggestive alignment of the form of gender conflict on the one hand and the form of expression of narcissistic pathology on the other. The set of patients with embodied gender issues include people with overt and covert narcissistic expression, but these expressions do not divide by gender; that is both male and female narcissists with this embodied gender conflict may be grandiose or depleted. However, in the set of patients whose gender conflict involves an issue of gender ideal there is a correlation between narcissistic presentation and gender; the men are more grandiose and entitled and the women are more depressed and passive. It appears that for those with embodiment issues, the basic sense of maleness and femaleness is not as binary or clear, and so it would follow that their expression of narcissism would not conform to the basic male/female distinction. However, for those patients

whose conflict is based in a rigid ideal of masculinity or femininity, the narcissism itself must be expressed within the frame of that ideal and therefore follows a societal division.

In the group in which the gender conflict manifests in relationships and involves an ideal of masculinity or femininity, the men present as more grandiose and the women as more depressed or deflated. This division of narcissistic presentation expresses itself along the culturally driven split suggested by Stone (1998): the men are concerned with ambition and monetary and social power, while the women emphasize attractiveness and being seen.

The men in this set present as hyper-masculine and are unable to need. They seem to have a fairly firm sense of self, but it is grandiose and unintegrated. Their grandiosity makes it difficult for them to succeed in their work, and they lack empathy for others in their lives. It is possible that this hyper-masculinity reflects a rigid self-representation, an inability to shift between different roles for the self (Eisnitz, 1981). These men also appear to have very harsh super-ego forerunners. They are not able to tolerate their own failures or even their needs. Their attachment to an ideal of tough manliness suggests a lack of integration. Their analysts report that these men have had neither a nurturing mother nor a father to idealize. Their masculinity appears to be a defense against the feminine and

the passive, and the rigidity may be a response to the conflict around passivity. The specific harsh, aggressive quality also suggests the internalization of the critical, rigid parent. In treatment, the analysts reflect on the difficulty in realizing that the therapy is important to these men.

The women in this group struggle with agency and tend to experience themselves as more passive objects of masculine desire rather than active subjects claiming their own pleasures. The gender conflict around femininity in these narcissistic women reflects issues that are prevalent for women in our culture and so a distinction needs to be made between their struggles and those of women without significant pathology (Benjamin, 1986; Dimen, 1991). Our culture over-emphasizes beauty, thinness and glamour so the line between the normal and the pathological can be blurred. Stone (1998) suggests that biologically, women's normal narcissism obliges them to "maintain and enhance their attractiveness as much as possible as a way of safeguarding their future for themselves and for the children they may hope to produce" (p.23). However, the woman presented here are preoccupied with an ideal of femininity, whether it be passive, beautiful or good, to the degree that anything outside that ideal profoundly threatens their sense of self, and these preoccupations significantly impair their capacity to relate to other people. The amount of emotional energy

devoted to the role of femininity and its rigidity reflect a lack of internal stability and self-esteem (Eisnitz, 1981).

From this small sample, it seems more difficult for the analysts to identify and/or engage with the unconscious aggression in the women with this more feminine/ covert form of narcissistic pathology. For example, Dr. L reports a passively seductive transference with the girlish woman, and says that he was not sufficiently aware of her aggression and so did not address it when she pulled back from treatment. Dr. T observes a conflict about wanting what she should not want in the transference dynamic with his patient who was photographed nude as a child. He focuses his discussion more on the desire than the aggression, but suggests that the pornographic book she writes, which they see as a production of the analysis, is a way to integrate the libidinal and the aggressive in a creative form and notes the importance of both. Dr. P, on the other hand, seems even less able to address her people pleasing female patient's aggression towards her. Dr. P attributes her patient's comments about being thin and spending money to a lack of awareness of the therapist rather than an act of cruelty or aggression.

The patients for whom gender conflict is expressed in their experience of their bodies are not divided by biological gender into overtly grandiose men and covert, depressed women. This is the set of patients comprised of

men who experience themselves as female and women who feel that their bodies are faulty or damaged. Since this set of patients does not experience themselves as fully male or female, their narcissistic presentations are not linked to biological gender. It is possible that the socially mediated difference in narcissistic presentation represented in the group with conflict about gender ideals is not seen in this embodied group because of conflicted early gender identifications. Both the men and the women in the group of patients with embodiment issues feel like women; the women may feel like faulty women, but they do not feel like men. This finding suggests that the ongoing identification with the female is powerful for both men and women with struggles in the gendered body, and supports theories that suggest the masculine identity is difficult to achieve because of the need for the switch in identification from the mother to the father.

Fogel (2006) suggests that, “all oedipal children, boys or girls, require both a ‘feminine’ facilitating and containing space and ‘masculine’ individualized and unique fantasy and thought” (p. 1147). For the patients with embodied gender issues, both the feminine containment and the masculine fantasy are missing because there is a disruption during separation, and this disruption leads to significant struggles with ego-structure. Eisnitz (1974) explains, “the more disturbance there has been with the

process of separation and individuation and the more immature the ego organization, the less stable the self-representation and the greater likelihood that there will be serious instability within it" (p.282).

Person (1999) suggests that disruptions in the separation individuation process are equally difficult for boys and girls, but for boys those disruptions are more apt to have consequences in the realm of gender identity. She argues that for the boys the need to stay identified with the mother makes the move to masculinity more complicated, while for girls the need to stay connected shores up female identity (although not necessarily an autonomous, authentic identity). This holds true for the group of patients with embodiment issues. The women in this group maintain a female identification even when a powerful narcissistic father is central to the early dynamic. One struggles with imaging the possibility that her body could give birth. For this woman, the intrusion of her mother may deprive her of a level of symbolic thought that would allow that imagining. The female patient who was rejected by her father for being a girl is a more phallic woman and her conflict is connected to her wish to be the loved son.

In contrast, the men, who have merged, intrusive mothers and absent, weak fathers, struggle with masculine identification. These men are Oedipal victors and love objects for their mothers, and are very identified with

their mothers who need their boys to be merged. Their issues are not only Oedipal. In each case, the mother is described as extremely intrusive, and this intrusion has the effect of diminishing the development of self-other differentiation. Due to this lack of separation and differentiation, these men also have a more borderline level of organization and less stable ego-structures (Bursten, 1973). Reich (1954) explains that ego-weakness stemming from early fixations at stages when ego boundaries are not yet stabilized allows for the ability to revive former ego states. It may be that the lack of firm ego in these patients makes them more likely to regress to the early maternal identifications. This regression would account for the loss of reality testing in bodily experience seen in at least one subject (the man who believed he was turning into a woman) and may explain why the men in this group appear more disturbed than the women. The fluidity of their gender identifications may also be a manifestation of identity diffusion. In two of these cases, the monster or man patient, and the man who thought he was turning into a woman, the transference is also very chaotic and the patients' experiences of the analysts fluctuate over the course of a single session. These transference shifts also seem to reflect the less firm ego-identity of these patients.

When the patterns of family dynamics are incorporated into the analysis, a relationship between parental involvement and the expression of gender conflict among these patients with narcissistic pathology emerges. Kernberg (1998) explains that narcissistic pathology develops when parents are unable to appropriately gratify physiological needs, the need for attachment and affiliation, the need for assertion and exploration, the need to react aversively through antagonism or withdrawal, and/or the need for sexual and sensual pleasure (p.116). She argues that the particular expression of narcissistic pathology may be attached to the specific needs that were not met. The list ranges from very early needs to needs that emerge later, but Kernberg explains that multiple failures may occur over time. In my small sample, the ways that the patients' needs went unmet are important in the adult expressions of gender conflict. Those patients with narcissistic pathology with intrusive parents tended to have embodied struggles with gender, while those with neglectful or critical parents tended to express their gendered issues in the realm of relationships. In the former there may be a less developed self-other differentiation, while in the later, the self is more separate, but is not fully developed because the infant has not been sufficiently mirrored. Particularly salient examples in these two areas are the men who feel female, who all have intrusive mothers and absent

fathers, and the women with rigid physical ideals of femininity, who all have neglectful mothers.

A relationship between gender conflict and narcissistic pathology

The prominence of gender conflict in these patients with narcissistic pathology raises the question of the relationship between narcissistic disorders and gender identity. I have discussed the patterns that emerge from this sample, and while these are suggestive, developing a comprehensive theory of the specific relationship is beyond the scope of this study. In this section, I will suggest some possible relationships between gender and narcissistic pathology based on different theoretical understandings of the developmental antecedents of narcissistic pathology, and discuss what seems to best illuminate the data. It is not possible to conclude, based on this small sample, that gender conflict is always implicated in narcissistic disorders. If narcissistic disorders occur because of disruptions earlier in development (Bach, 1994; Kohut, 1971), then gender would always be implicated, but if narcissistic pathology develops later (Kernberg, 1984) then gender would not necessarily be implicated. It is also possible that core narcissistic issues like the fantasy of omnipotence and issues of disregulation may interfere with the capacity to develop comfort with one's gender. For some

narcissistic personalities, there may be an inability to tolerate the limits imposed by gender because there is a fantasy of omnipotence that includes the possibility of being both genders. The problem of gender may also be another expression of disregulation: a lack of balance between the male and female parts of the self. These relationships are interesting to explore in treatment, but a developmental model would be a valuable addition.

One possible model, following Kohut, is that narcissistic pathology occurs early in development and interrupts the capacity to develop a fully gendered self. One subject, Dr. J, explains the lack of an authentically gendered self in patients with narcissistic pathology using this model. He argues,

> Because, you see, in my experience people with this kind of pathology really don't have a firm gender. So it doesn't matter whether they're men or women – they don't feel like men or women. That's very often the case. Gender differentiation occurs later than the pathology that we're talking about. So if you get early disregulation in the dyad that's going to lead to a narcissistic disorder, then the stuff that's there for making a firm gender commitment doesn't get, it never gels. So what you hear, not when you talk to somebody once a week, face to face, not then, but when

> you actually see somebody in analysis four or five times a week on the couch — what you hear is that they don't know who they are. And that includes gender.

This observation seems to explain some of the patients presented in this study, but is less illuminating for those patients with more rigid ideals of hyper-femininity and hyper-masculinity. Perhaps these roles can be understood as defensive maneuvers against not knowing, but it is not clear why some would become more rigid and others more diffuse.

The phenomenon that emerged from the data suggests to me that, for these patients, the same early experiences, patterns of identification and defensive structures developed into both narcissistic pathology and gendered conflicts. Disruptions may occur in the earliest stages of merger, later in separation, or in both. In this sample it seems that the developmental achievements in ego functioning seem related to the severity of gender conflict. The specific manifestation of the gender conflict and the expression of narcissistic pathology seem to depend on the core relationships in the family and where and when the greatest struggles occur. For example, in rapprochement the struggle of otherness comes to the fore, and both narcissistic and gender issues might develop. Benjamin (1986) explains,

> It is precisely in rapprochement that the awareness of

> gender identity emerges. The difference between mother and father begins to take hold symbolically in the psyche and to meld with the vital conflict between separation and connectedness, independence and dependence. The struggle for recognition joins with the moment of differentiation between mother and father; differentiation between self and other, male and female, become structurally intertwined (p.121).

This theoretical model is further supported by recent literature on gender and analysis. While the relationship between narcissistic disorders and gender struggles has not been specifically explored, the idea that the development of gender is a part of the development of the self has been discussed by many gender theorists (Benjamin, 1998; Dimen, 1991, Harris, 1991; Sweetnam, 1996). From this perspective, it is virtually axiomatic that a disorder of the self would include issues of gendered conflict. Fogel (2006), referencing Adrienne Harris, states “gender and self are softly assembled though countless experiences of personal, familial, and culturally mediated interactions” (p. 1146). So, it makes sense that a narcissistic disturbance would implicate gender development and that disruptions (whether internal or interpersonal) could lead to both narcissistic and gendered struggles.

Implications for Clinical Work

Narcissism is increasingly prevalent in our culture, and treatment with patients with narcissistic pathology continues to be difficult (Bromberg, 1986; Lieberman, 2000). Bromberg (1986) discusses new ways of thinking about treatment with patients with narcissistic pathology and suggests that some of the advances come from new understandings of the disorder. He argues, "it is not the definition of narcissism arrived at as much as the struggle to arrive at one, which is the essence of recent progress in psychoanalytic thought" (p. 438). Considering the experience of gender in patients with narcissistic pathology adds another dimension to understanding pathological narcissism, and may help to illuminate some of the issues that arise in the lives and treatment of patients with narcissistic pathology.

Patients with narcissistic pathology may or may not present with material that is explicitly gendered, but even when they don't, the gender conflicts and ambivalence may be important. In this sample, only one of the people presented with a clear gender issue, but in each case the struggles around gender became important in the treatment for understanding the patient and the transference. My research suggests that clinicians should stay alert to the gendered conflicts in their patients even when they are not immediately apparent.

In this sample, the way people expressed/experienced their gender conflict was not indicative of their level of functioning in other areas of their lives so it is something that might not be immediately apparent. It is possible that one of the differences between patients with narcissistic pathology with gender conflict and borderline patients is that the stability of the narcissistic self makes even gender conflict less disruptive in their lives. Even so, it seems that men with severe narcissistic pathology may be more likely to regress to female identifications. For these men, there is significant gender confusion related to a borderline level of organization, and that confusion may be a reflection of identity diffusion.

When it emerges in treatment, the gendered material may come across in issues of the body, interpersonal issues or struggles with agency. This material also may come to the fore in the family histories and the personal gendered narratives. As clinicians hear these issues in the room, they should consider the effect of the ungendered or gender ambivalent self on the patient's relationship to his or her body, to others in his or her life, and to the clinician him or herself. These issues may seem self-evident, but from the literature currently in the field, it appears that they are often not immediately present in our minds.

Limitations of the study

This study is a preliminary exploration of a clinical phenomenon that has not previously been examined. To best explore this phenomenon a small sample of analysts who self-selected from those approached was interviewed using a semi-structured clinical interview that asked for narrative data about patients and that data was then analyzed using a thematic, qualitative analysis. Each of these elements contributes to the strengths and sets the limitation of this research.

A small sample size was used to begin to develop an understanding of the phenomenon. The sample consisted of well-established analysts who have particular experience with issues of narcissism and/or gender. This population is distinctive for being reflective about themselves and their patients, but their personalities and theoretical orientations likely had some bearing on their responses. The subjects volunteered and were willing to discuss clinical material with the researcher and as such were self-selecting from a larger pool of analysts approached. In addition, subjects selected patients that they wanted to discuss. These patients may have been more in mind for a number of reasons including particularly positive or negative treatment experience, intensity of pathology, recent treatment or cases that they have published. The patients may not be, therefore, a representative sample of

patients with narcissistic pathology even of these analysts. Given that the analysts self-selected to participate in this study and then chose the patients they felt were relevant to the discussion of narcissism and gender, the findings in this study may not be generalizable to the full population of patients with narcissistic pathology.

Data was obtained through an open-ended interview to allow for a detailed discussion of clinical material and a full exploration of relevant concepts. This method provides detail and nuance, but does not provide the precision of cross-subject comparability of quantitative data. The interview was also a self-report of the subjects' work with patients and the data is therefore the analysts' own perspectives on the patients and the treatment (not the patients'). The material presented may be influenced by the analysts' current feelings about both the treatment and the interview situation. Subjects may have been somewhat protective of their patients and/or their work and chosen not to report all of the struggles that might be relevant to the issues addressed in this thesis. There may also be issues of which the analysts are less aware. This method allows for analysis of the material as understood and reported by the analyst in a setting that appeared to be safe, but there is no objective or external validation of the data.

Suggestions for Future Research

This study began as an exploration of the experience of, and with, male and female patients with narcissistic pathology and developed into an exploration of the phenomenon of gender ambivalence in both men and women with narcissistic pathology. The clinical material presented here is only a beginning, the opening of a theoretical conversation about this particular phenomenon, and an attempt to understand gender conflict in patients with narcissistic pathology in the larger context of the relationship between gender and narcissism. Future research should expand on this understanding, delving further into the specific narcissistic experience of gender and its relevance to treatment.

Further research should include a larger sample of analysts and a larger sample of patients with narcissistic pathology. The nuanced views and depth of experience expressed in the material shows that analysts are a rich source of data on the subject of narcissism and gender and a larger sample size would help to flesh out the experience more fully and provide greater generalizability, as well as counter-examples.

Future studies should also focus specifically on patients with narcissistic pathology who experience gender conflict/ambivalence to directly explore the development and expression of that conflict. As this research did not begin

with an understanding of the phenomenon or its relevance, the questions in the interview were not focused in this area. Questions about how specific experiences of gender relate to narcissistic presentation and to the course of treatment could be particularly helpful.

If appropriate patients could be identified, and were willing to participate, it would be very interesting to interview the patients themselves to explore the experience first hand of their gender struggles. This research would add a more personal, descriptive element to the experience, but might be difficult if the patients lack insight. If possible, it would be interesting to see how the patients themselves frame the development of their gender in terms of their own family histories, including their relationships to their parents and their siblings.

Conclusion

Even with the prevalence of narcissism in the culture and the consulting room, a consensus has not been reached as to the pathology's etiology or it's structure. The elusiveness of a definitive theory of narcissistic pathology may be due, in part, to the wide range of possible narcissistic presentations. I believe, however, that narcissistic pathology involves a disturbance in both the self-structure and in the capacity for object relations. I argue that there is a gendered component to the specific

disruptions in development that lead to narcissistic pathology, and there is, therefore, frequently an experience of gender conflict in patients with narcissistic pathology. While I have chosen to use the word conflict, I should point out that there is not necessarily a conscious conflict around gender, but rather there are struggles that can be rooted in the experience of being male or female.

From the experiences of the small sample of patients presented by the analysts interviewed for this study, I identify two different expressions of gender conflict in patients with narcissistic pathology. In one, the patient has a feeling of not being fully male or female, and this experience is understood through feelings about embodiment, the experience of the physical, gendered body. The other experience of conflict is based in a need to rigidly adhere to an ideal of masculinity or femininity, and this form is frequently expressed in relation to an other.

The men in the group with issues of embodiment experienced real gender confusion, but the women did not. I suggest that the men's gender confusion can be understood as stemming from their identifications with their intrusive mothers. These men were unable to separate and thus to develop strong self/other boundaries. They have a lower level of organization and are therefore more apt to regress to early female identifications. The women in this group also struggle with identification, but because of the

primary maternal connection, these struggles express themselves as faulty or despised femaleness rather than actual gender confusion.

In this sample, I also found that the commonly referenced experience that men are more apt to present with the grandiose/ over-inflated type of narcissism while women are more apt to present with a more covert/ depressed form held true in those patients whose gender struggles are experienced in rigid gender ideals, but not for those whose conflict is with embodiment. Those patients who have a rigid gender ideal present with the narcissistic issues that best fit that ideal— independence and toughness for men and passivity and beauty for women. This set of patients also tended to have more critical and neglectful parents and this correlation suggests that these patients may have a clearer self/other differentiation, but a pathological self that relies on an other for reflection.

My sample is too small and selective to be conclusive, but the patterns that emerge from this study suggest interesting relationships between early gendered family dynamics, expressions of gender conflict and narcissistic presentations that seem related to early identifications and firmness of ego structure. These patterns suggest that there may always be some experience of conflict around gender in narcissistic pathology, but the quality and

severity of that conflict will vary.

As our cultures norms for men and women shift, and there are new understandings of the role and meaning of gender, it is important to integrate the awareness of gender into our understanding of our patients and clinical practice. Gender is not simply fixed or fluid, but is experienced historically and presently in ways that are powerful and meaningful to our patients themselves and those around them. Future research should continue to explore how these nuanced experiences of oneself as a gendered being influence and are influenced by the complexities of character pathology, and how these intersections play out in psychoanalytic treatment.

Appendix A

Dear [Prospective Participant],

I am a doctoral candidate in clinical psychology at The Graduate Center of The City University of New York and am working on a dissertation on the role of gender in the development, presentation and treatment of narcissistic character pathology. As part of my research, I am conducting interviews with psychoanalysts on their work with male and female patients they see as having had an early injury to the self and to be struggling with significant narcissistic issues. [Referral] recommended you to me, and I am writing to ask if you would agree to be interviewed about the subject.

The purpose of this study is to investigate different ways that individuals with narcissistic issues may present in treatment and to explore both the developmental routes of these presentations and the experience of treating these individuals. While much has been written about the overtly grandiose, entitled narcissistic character, in this study I am particularly interested in the development and presentation of less overtly grandiose, more covertly entitled individuals and the experiences of transference and countertransference with these individuals. I would like to interview you about your clinical experience with patients with narcissistic disorders, however they initially present, and your understanding of the development of their issues.

The interview takes approximately one and a half to two hours and is divided into four sections. The first is a brief discussion of participants' thoughts on narcissistic disorders. In the second, I ask participants to informally discuss specific cases, and to compare male and female patients struggling with early injuries to self. The third section is a series of questions addressing different forms of narcissistic pathology and the fourth allows for a discussion of any issues that the previous sections may have raised.

The confidentiality of the therapists and their patients is, of course, assured. I am audiotaping the interviews and all tapes and files are identified by subject number rather than name and are kept in a locked cabinet. Any identifying clinical information will be obscured during transcription of the interviews to protect patient anonymity and I will not include the names of therapists, patients or professional agencies in any written or oral presentation of the findings of this project. Since I plan to ask specifically about case material, each participant will be given the opportunity to review the transcript of his or her interview to ensure that patient confidentiality has been maintained. The study, including plans for insuring confidentiality has been approved by the Institutional Review Board of the City College of The City University of New York.

I understand that I am asking for a significant amount of your time, but I have found that a shorter period does not allow participants to fully respond to the questions. I would greatly appreciate your involvement and believe your clinical experience and insights would add tremendously to this project. Should you agree to participate, I will attempt to schedule the interview at the time most convenient to you and can be available on evenings and weekend if you prefer.

I will telephone you in the next week to ask if you would be willing to be interviewed. If you prefer to contact me, you can reach me at 917 821-7347. I look forward to talking with you.

Sincerely.

Anna Kramarsky, M.A.

Appendix B

Interview Questions

Phenomenology

Can you talk briefly about how you define narcissistic disorder/ character pathology?

How do you know a patient has primarily narcissistic

character pathology?

What do these patients feel like to you?

As you speak about these issues, who is the first patient that comes to mind?

Can you tell me about him/her?

Gender (begin with whichever patient was first presented)

Let's talk a little about a female narcissistic patient.

- Presenting problem
- Treatment
- Experience of grandiosity
- Development
- Relationships/ use of object
- Body

Let's talk a little about how a male narcissistic patient.

(Probe for specifics of body, experience of gender, use of object, grandiosity)

If has not been discussed…Do you see a difference in the issues of men and women whom you see as primarily narcissistic? If so, how do you understand that difference? Has this changed over the course of your practice?

Do you find that there are differences in the therapeutic

relationship or processes with male and female narcissistic patients?

Let's talk a little about transference and countertransference with these patients.

(Probe for experience in initial meeting and particular struggles/conflicts in treatment)

Covert/ Overt

I am sure you are familiar with the recent literature on narcissistic typologies—covert and overt narcissism and the differing levels of expressed grandiosity in each.

What do you think about these types of narcissism? Do you believe they exist as separate entities?

If so,

There is much more written about the overtly grandiose presentation, can you tell me about patients who present with more inhibited, covert narcissism.

(probing for particular presentations and the experience of gender, the body and rage).

Can talk a little about a particular patient who presents this way? How do you conceptualize him/her?

Do you think the two types have different developmental pathways or a common development route? Can you talk a little about that route (or those routes)?

If not,

How do you understand the clinical presentations of these

different qualities?
What are the developmental reasons for these manifestations?

If the analyst has described experience with a more covert narcissistic patient,
What is treatment like with a more covert, inhibited narcissistic patient?
(again probing for initial experience/thoughts and then patterns of transference and countertransference)
What are the particular difficulties in treatment with these patients?

Do you see any overlap between overt and covert narcissism and the gender of the patient, or is there no gender effect in your experience?

Are there theories that you have found particularly helpful in working with narcissistic patients?

Debriefing

Has this interview in which you have been asked to discuss your narcissistic patients with a focus on gender and narcissistic presentation elicited any new formulations for you?

Is there anything else that you would like to add or

highlight?

Appendix C

PARTICIPANT CONSENT FORM

Name_____

Date_____

I understand that the purpose of the study is to explore the role of gender in the development and presentation of narcissism and to explore the experience of and treatment with more covertly narcissistic patients. Further, I know the study will focus on my clinical work and my thoughts about that work.

If I choose to take part, I agree to meet with the interviewer for approximately 2 hours to discuss my experience with patients.

I understand that my responses to all of the interviewer's questions will be tape recorded and will remain confidential. On the tapes I will only be identified by a participant identification number. I will not be asked my name, address or phone number during the taping but I will be asked to provide the information on a separate sheet of paper. I understand that this information will be kept separate from the interview tapes. By signing this form I

agree that I am willing to be contacted in the future for possible interviews although I am under no obligation to participate.

While I may find the interview interesting and learn something from it, I understand that the purpose of this research is not for my immediate benefit. I will be offered the opportunity to review the results upon completion of this research.

I have been given the opportunity to ask any questions I have about my participation in this study. I understand that my participation will not subject me to any physical risk or significant psychological distress. Further, I have been informed about the system for insuring my confidentiality and have no concerns on that matter.

Since my participation is voluntary, I understand that I can stop at any time.

If I have any questions or complaints about my rights as a subject, I may call Ethel Breheny, Institutional Review Board Administrator, at 212-650-7903 during office hours. If I have any further questions about the study, I may call Anna Kramarsky at 212 979-7711 or Dr. Diana Diamond, Professor of Psychology at the City College of the City

University of New York at 212-877-2232.

I have been given a copy of this form to keep.

I agree to participate in this study.

_____ _____

Signature Print Name

Witness:

_____ _____

Signature Print Name

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