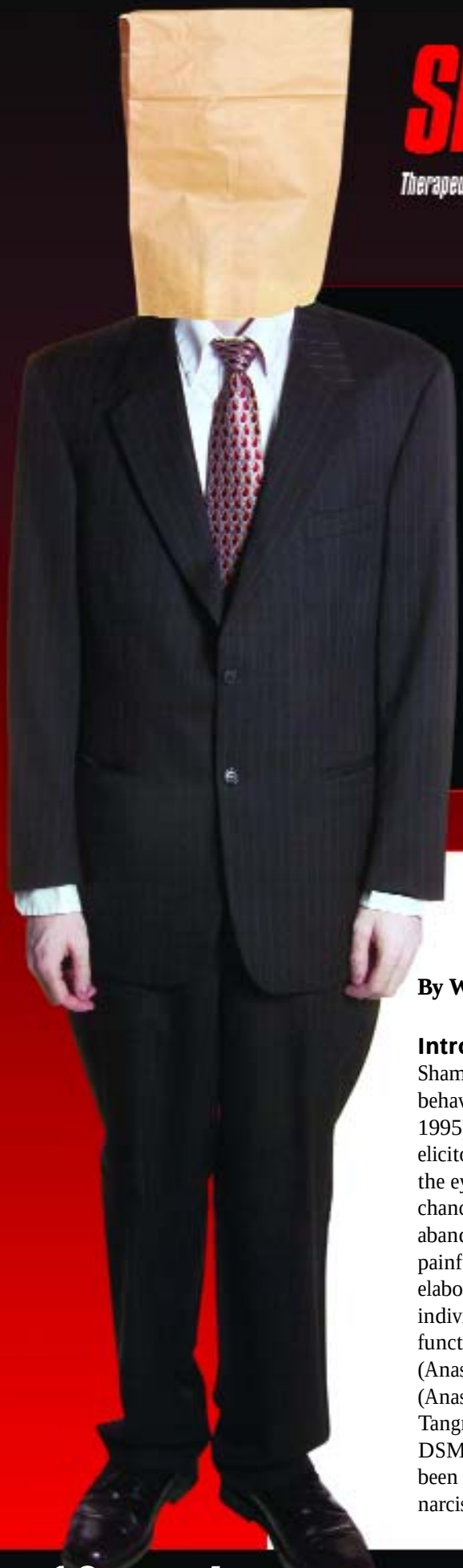

Shame and Narcissism:

Therapeutic Relevance of Conflicting Dimensions of Excessive Self Esteem, Pride, and Pathological Vulnerable Self

Abstract

Shame and rage are principal emotional manifestations that intertwine in narcissistic personality disorder (NPD). In this article, the dimensions of shame and serious vulnerability are studied as they conflict with the dimensions of pride and excessive self-esteem. Suggestions are made for the psychotherapeutic handling and constructive utilization of narcissistic shame. More research is needed into the conflicting dimensions of the internal world of persons with NPD and the intrapsychic, psychosocial, cultural, religious, ethnic, and neurobiological dimensions (and the interplay between them) of the shame-rage mechanism in order to provide more adequate assessment and treatment programs.

Key Words: narcissism, self-esteem, pride, vulnerability, therapeutic humor

By Willem H.J. Martens, MD, PhD

Introduction

Shame can play a central role in motivating and regulating people's thoughts, feelings, behaviors, achievements, and social adaptations (Campos, 1995; Fischer & Tangney, 1995). Most people spend a great amount of time avoiding social disapproval, a strong elicitor of shame and embarrassment. Individuals worry about losing social status in the eyes of others and, as Goffman (1955) noted, every social act is influenced by any chance of public shame or loss of face. The external danger of experiencing shame is abandonment or rejection (Morrison, 1983). Shame can be such a self-damaging and painful emotion that shameful experiences may automatically be suppressed through elaborate cognitive reappraisals (Morrison, 1983). Although shame can protect an individual's integrity and can be a modulator of interpersonal relatedness, it can also function as a defensive psychopathological state. Shame is associated with narcissism (Anastasopoulos, 1997; Gramzow & Tangney, 1992), depression, and chronic anger (Anastasopoulos, 1997; Harder et al., 1992; Lewis, 1971; Tangney et al., 1996; Tangney et al., 1992). Harder (1995) revealed that shame is a core component of the DSM-IV definition of NPD (American Psychiatric Association, 1994). Shame has been considered as the master emotion and the dysphoric affect underlying states of narcissism and vulnerability (Morrison, 1989).

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Definition of Shame

Shame is the sinking apprehension of not measuring up to something or somebody, the fear of being exposed as deficient in some important way, and, above all, a sense of personal inadequacy. Experiencing shame in extreme forms has a way of cutting to the bone of an individual's sense of basic worth and his or her ability to survive and cope. When a painful moment arises, shame often serves as a background feeling that underlies other feelings and experiences and may be subjectively felt as if it is hopeless and unchangeable. Shame seems to have to do with "being," and not just "doing." Extreme cases of shame are recognized clinically as states of great vulnerability and reactivity for self-destructiveness and other-destructiveness (Lee, 1995; Wheeler & Jones, 1996).

Shame is felt as an inner torment, as a sickness of the soul. It is the most poignant experience of the self by the self, a wound felt from the inside, dividing individuals from both themselves and from one another. Shame is the source of many of the following complex and disturbing inner states: depression; alienation; self-doubt; isolating loneliness; paranoid and schizoid phenomena; compulsive disorders; splitting of the self; perfectionism; a deep sense of inferiority, inadequacy, or failure; the so-called borderline conditions; and disorders of narcissism. These are all rooted in shame. Each is rooted in significant interpersonal failure (Kaufman, 1980, 1989).

This article defines shame as an egocentric, self-conscious emotion based in and starting from primitive unconscious drives and desires and physiological states. These states correlate with self-defense impulses as a reaction to rejection. This physiological flight-fight mechanism can be observed in animals, but will mostly be taken over by consciousness (cognitive abilities) in humans in order to cope with humiliation/rejection and minimize the damaging effects rather than analyze the origins of failure and blaming behavior (which requires introspective, empathic, and moral activities). Furthermore, in this process of shaming, intrapsychic, psychosocial, cultural, ethnic, and religious aspects (values and norms), as well as a neurobiological condition, might play a significant role.

Significant Distinctions Between Shame and Guilt

Stability and globality attributions distinguish the causal antecedents of shame and guilt. Shame involves negative feelings about the stable, global self, whereas guilt involves negative feelings about a specific behavior or action taken by the self (Lewis, 1971; Lewis, 2000; Tangney & Dearing, 2002). Several lines of research support this distinction between shame and guilt. In particular, research on achievement attributions has shown that individuals who blame poor performances on ability (an internal, stable factor) are more likely to feel shame, whereas individuals who blame poor performance on effort (an internal, unstable factor) are more likely to feel guilt (Brown & Weiner, 1984; Covington & Omelich, 1981; Jagacinski & Nicholls, 1984; Tracy & Robins, 2002). Studies on behavioral outcomes of emotions have shown that shame often leads to escapist or hiding behaviors, suggesting an incurable impact to the stable, global self (see Tangney, Burggraf, & Wagner, 1995). In contrast, guilt has been associated with reparative behaviors (suggesting an impact on aspects of the self that can be changed) (Barrett, 1995; Batson, 1987; Baumeister et al., 1994; Doosje et al., 1998; Tangney & Dearing, 2002) and pro-social behaviors such as empathy, altruism, and caregiving (e.g., Batson, 1987; Baumeister et al., 1994; Tangney & Dearing, 2002).

The Shame-Rage Dynamic and Narcissism

Theorists such as Kohut have asserted that shame and rage are "the two principal experiential and behavioral manifestations of the disturbed narcissistic equilibrium" (1972, p. 379). The "shame-rage spiral" observed in clinical research has been noted to be particularly characteristic of narcissists (Lewis, 1971; Scheff, 1998). The shame-rage dynamic is the phenomenon of becoming angry after being shamed. Shame that has been transformed through regulation into some other emotion, usually anger or hostility, is called bypassed shame (Lewis, 1971; Scheff et al., 1989). It is postulated that shame emerges out of self-depletion and that narcissistic rage emerges out of self-fragmentation (Grosch, 1994). Rage is more tolerable to individuals with NPD than shame and envy, which are associated with helplessness, a sense of ugliness, and impotence (McWilliams, 1994). Also, narcissistic hubris may contribute to aggression and hostility, interpersonal problems, relationship conflict, and a host of self-destructive behaviors (Bushman & Baumeister, 1998; Campbell, 1999; Kernberg, 1975; Kohut, 1977; Morf & Rhodewalt, 2001; Wink, 1991). This article speculates that pride in patients with NPD might function as an emotional buffer against the threats of the external world, and, when necessary, they defend this buffer by means of hostile or aggressive acts. In fact, narcissists want to destroy anyone doubting their grandiosity and disturbing their strong image. Oldham et al. (1990) suggested that narcissists can also experience such inappropriate rage in response to someone diminishing their sense of superiority. They attack and attempt to destroy the source of criticism, even when this criticism is unmistakably

provoked by their own failure (Bushman & Baumeister, 1998; Kernis et al., 1993). Narcissistic self-enhancement biases may promote external attributions for failure (blaming others) (Bushman & Baumeister, 1998). According to Brown and Dutton (1995), narcissists tend to globalize failure. For a narcissist, internalization of failure would be internalization of global failure, leading to shame without any possibility of guilt. The only regulatory solution for these individuals is to externalize blame and experience anger and rage instead (Tracy & Robins, 2004a, 2004b). This article suggests that when individuals with NPD fail to avoid shame as a consequence of personal failure (they cannot adequately transform their failure into anger and rage, or they cannot convince themselves that others are responsible for their failures), they will experience a form of shame without an introspective, self-analyzing dimension. This article asserts that this kind of shame is characterized only by emotional suffering as a result of rejection and an awareness of an individual's lack of great importance and incapacity to impress other people.

If these individuals lose their narcissistic feelings of easy superiority, they become irritable, annoyed, and subject to repeated bouts of dejection and humiliation (Millon & Davis, 1996). Interestingly, Milon and Davis observed that when individuals with NPD experience a loss of confidence, they become enraged and may experience feelings of shame and emptiness after acting out. Millon and Davis did not specify whether these feelings of shame and emptiness were the results of repeated bouts of dejection and humiliation or of regretting that the outside world could interpret their acting out as lack of self-control and primitive/banal behavior. Acting out, and related lack of self-control, will reveal a significant character failure to the outside world, namely a lack of dignity/gentleness, a feature that is supremely desired by many persons with NPD. This article concludes that after acting out, the defense of patients with NPD apparently melts down as a consequence of episodic burn-out and emptiness, and shame emerges and seems inescapable. Narcissistic patients realize that other people's respect and admiration can never be regained by acting out.

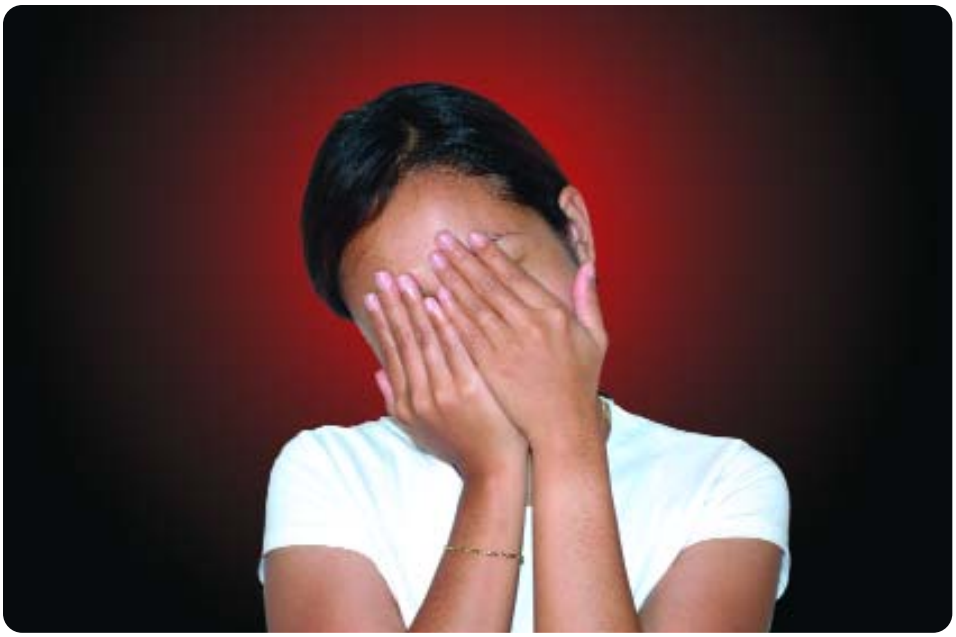
Self-Experience of Small, Vulnerable, and Weak Self

Morrison and Stolorow (1997) and Cooper (1998) consider narcissism, in its broad context, a reflection of all aspects of self-experience, including the experience of oneself as expansive, grand, independent, and autonomously sufficient; or in a contracted sense, as small, vulnerable, weak, and shameful. The role of shame in the development of the pathological grandiose self is evident because of an awareness and fear of weak self-structure (Cooper, 1998).

Narcissistic patients demonstrate very vulnerable characteristics. Individuals with NPD may show little real ability outside of their fantasies. They can become self-destructive because their grandiosity and self-preoccupation impair their judgment and perspective (Oldham et al., 1990). As they consistently devalue others, they do not question the correctness of their own beliefs; they assume that others are wrong (Millon & Davis, 1996). Individuals with NPD are trapped in a kind of perfectionism. They have unrealistic ideals for themselves and either convince themselves that they have attained these ideals (the grandiose posture) or feel like a failure and inherently flawed (the depressive posture) (McWilliams, 1994). The NPD illusion of superiority is a facet of a generalized disdain for reality. Even as these individuals inflate their efforts and overvalue their abilities, they seem surprised when they do not receive the praise they expect (DSM-IV, 1994). They appear to have little awareness that their behavior may be seen as objectionable or irrational (Millon & Davis, 1996). If rationalizations and self-deception fail, individuals with NPD are vulnerable to dejection, shame, and a sense of emptiness. Then they have little recourse other than fantasy (Millon & Davis, 1996). Even individuals with NPD who may be talented and successful enough to be admired and emulated by others (McWilliams, 1994) and who can be nearly symptom-free and well functioning may still be chronically unsatisfied due to habitually unrealistic self-expectations (Sperry & Carlson, 1993).

The characteristic difficulties of individuals with NPD almost all stem from their lack of solid contact with reality. If the false image of self becomes substantive enough, their thinking will become peculiar and deviant. As a result, their defensive maneuvers become increasingly transparent to others (Millon & Davis, 1996). The strain of maintaining a false self-image may lead to feelings of fraudulence, emptiness, and dejection (Millon & Davis, 1996). McWilliams (1994) believes that individuals with NPD have some sense of their psychological fragility. They can experience either a grandiose self-state or a depleted, shamed self-state. With external affirmation they can feel self-righteous, prideful, contemptuous of others, self-sufficient, and vain. With the loss of external validation they can feel a vague sense of falseness, envy, ugliness, and inferiority. In accordance with long-lasting psychotherapeutic treatment and research activities, this article suggests that many patients with NPD episodically experience and are aware of both the strong and vulnerable dimensions of their personalities.

The motivational core of narcissism is a yearning for absolute uniqueness in the eyes of a designated, idealized other; a yearning to be the one that matters most to that designated other. This article asserts that most narcissistic persons unconsciously feel and/or know from time to time that such brilliance and uniqueness is not attainable, and, as a result, experience feelings of intense shame. A significant weak point in the character and development of patients with NPD is that they do not have a realistic view of, nor do they accept, these vulnerabilities and their real self. These blind spots and sustained, long-lasting ignorance might lead to self-neglect, self-betrayal, a false self-image, and destructive self-expression. As a consequence, self-reparation is impossible. Furthermore, this article suggests that negation of the vulnerable sides of themselves and their incapacities might make them even more vulnerable because they are, as a result of their unrealistic self-image and unfounded sense of their own capacities



and limitations, unable to anticipate and avoid adequately dangerous threats and challenges. As a result, negative, frustrating, and even traumatic experiences might bring about depression and shame that in turn will lead to more anger and acting out.

Pride, Self-Esteem, Avoiding Shame, and Self-Representations

Shame reflects feelings about a defect of the self, a lowering of self-esteem, a failure to meet the values of the ego ideal, and a flaw in one's identity representation (Kohut, 1971, 1977). Thus, where grandiosity is conscious and central, there is a distinct shame-avoidance quality. Where grandiosity is disavowed, although unconsciously present, there is a heightened sensitivity to shame (O'Leary & Wright, 1986). Without positive self-representations, narcissists would be overwhelmed by shame and low self-esteem (Kernberg, 1975). Thus, narcissists may regulate self-esteem both to avoid shame and to experience conscious feelings of hubristic pride. These processes include a tendency to chronically focus attention on the self; appraise positive events as identity-goal relevant and congruent and negative events as identity-goal irrelevant and incongruent; and make internal, stable, and global attributions for success and external attributions for failure. Self-conscious emotions such as shame and hubristic pride are assumed to fuel narcissistic self-esteem regulation (Robins et al., 2001; Wright, Lichtenfels, & Pursell, 1989). Individuals with narcissistic tendencies report high self-esteem, but hold implicit negative self-representations (e.g., Broucek, 1991; Kernberg, 1975; Morrison, 1989; Tracy & Robins, 2003b; Watson et al., 1996). In addition, these individuals are highly motivated to self-enhance and self-aggrandize (John & Robins, 1994; Morf & Rhodewalt, 2001), presumably because maintaining biased self-representations allows them to prevent their implicit low self-esteem from becoming explicit. Narcissists, like all individuals, regulate self-esteem by striving to increase pride and avoid shame. To maintain self-esteem and avoid shame, individuals with NPD take credit for success and externalize blame for failures (Greenwald, 1980; Harvey & Weary, 1984). Narcissists may not focus attention on the self when negative events occur (Tracy & Robins, 2004a, 2004b). To avoid shame, individuals may appraise negative events as identity-goal incongruent, either externally caused or internally caused but due to an unstable, specific aspect of the self (Tangney & Dearing, 2002), or they might deny that an event is incongruent with or even relevant to identity goals (Tracy & Robins, 2004a, 2004b). Negative aspects of the self are met with denial or rationalization (Richards, 1993). They may reappraise negative events as irrelevant to identity goals by, for example, shifting the importance of various identity goals (e.g., "It's ok that I failed my exam because I don't want to be a doctor anyway—I'd rather look cool to my friends"). Conversely, to increase pride, individuals may appraise positive events as identity-goal relevant and internally caused. For example, after receiving a high score on her math exam, the narcissist may think, "I'm smart and talented at everything I do," whereas a non-narcissistic person may also make an internal attribution but think, "I'm pretty good at math," or even "I'm learning the material in this math class very well." Interestingly, narcissists may make self-serving attributions even when positive events are not actually internally caused. Narcissists tend to take credit for events that may be caused by others (Farwell & Wohlwend-Lloyd, 1998; Tracy & Robins, 2004a, 2004b).

Maintenance of the belief that they are superior, often without commensurate achievements, can create a painful disparity between NPD patients' genuine and illusory competence. Avoiding shame by enhancing pride and self-esteem will come into conflict with the patient's unconscious self-knowledge and awareness of his or her limitations, vulnerabilities, and incapacities. Furthermore, it could easily attack his or her emotional, mental, and motivational condition (certainly when the patient becomes older) because such intensive and long-lasting bouts of shame avoidance and efforts to increase unrealistic-based pride are very energy consuming and might lead to burn-out and/or the neglect of other necessary non-selfish activities (social-emotional interactions and associated abilities; occupational, relational, and societal duties). The consequence might be serious social isolation, social-emotional failures (and very painful experiences as a consequence), serious rejection, a lack of acceptance, and a lack of respect from other people. Furthermore, in the long run it will be more difficult for them to convince themselves and the outside world of their uniqueness and superiority.

Shame as a Therapeutically Relevant Emotion

Narcissistic shame might be highly therapeutically relevant because, as previously noted, shame and associated rage are the two principal experiential and behavioral manifestations of the disturbed narcissistic equilibrium (Kohut, 1972) and because of the regulating and motivational role in social adaptation and change of attitude (Campos, 1995; Fisher & Tangney, 1995). Furthermore, Einstein and Lanning (1998) revealed that shame is greatest for individuals at intermediate stages of ego development. This article suggests that shame could be used in therapeutic settings for reality testing; motivation for changing attitudes; investigation of instinctual drive, unconscious desires, and incapacities and activities that form the basis of narcissistic shame; stimulation of moral activity and self-reflection; and transformation of negative emotions into positive emotions.

Reality Testing

It was discussed before that patients with NPD seriously lack reality-testing ability and interests in order to maintain their feelings of superiority. When patients experience shame during the therapeutic process, it is important to explore the origins of it and how it is linked to the patients' deviant attitude, false self, vulnerabilities, limitations, incapacities, and failure. This exploration should be done in such a manner and tempo that the patients are able to understand and cope with it. In this way patients can become aware of the conflicting dimensions of their character (superiority, pride, and grandiosity on one side and vulnerability, fear, and social-emotional incapacities on the other). As a consequence of this investigation, the narcissistic patients might realize that it is necessary to examine and accept the reality of their internal world, character, related vulnerability, and incapacities before they can change. The therapist now must play a very supporting role because the patient must go a few difficult steps further when trying to solve his or her core problems and change his or her attitude. Psychotherapist and patient must plan the most adequate route for treatment (eventually a combination of psychotherapy, psychosocial guidance, and/or neurologic treatment), training (psychosocial skill training, sports, drama), and education (psycho-education—academic success might have a positive effect on patient's attitude, self-esteem, and social-emotional growth). Acceptance of their real self and internal reality might result in authenticity and a more relaxed attitude toward the external world and themselves, and it might increase their possibilities for social interactions and close bonds. Furthermore, acceptance of one's real self will lead to exploration and contact with one's emotional self (and correlated increased empathic and other emotional abilities) and one's moral self (and related enhanced social-emotional awareness and moral capacities). This might decrease illusionary feelings of superiority and lessen the tendency to devalue others. Showing one's real self might evoke real respect from other people that, in turn, might help a patient develop a healthy and solid form of self-esteem in place of his or her excessive and unrealistic self-esteem. In this manner patients can become aware that their vanishing and pathological self-esteem is fragile and can only be maintained by excessive external affirmation. They might also become aware that their presumption of superiority is an illusion. They might help them become capable of feeling secure and content without thinking highly of themselves. They might experience increased awareness of the fact that too strong of a focus on making impressions on other people is not a good basis for social bonds and interactions, and they might realize that living in harmony with the true self might contribute to their process of improvement or recovery.

> "When [the narcissist] is incapable of drawing attention in a normal manner by showing his or her real character and capacity, he or she may provoke excessive attention from other persons by utilizing his or her false self and simulating his or her uniqueness, resulting in shame (because the real self did not garner this attention)."

Motivation for Changing Attitude

Shame can also result from the (therapeutic) unmasking of the person's real intentions, character, and limitations. Shame in this context can be utilized for further self-investigation and might bring about strong motivation for avoiding shame in the future by attempting to change attitudes and diminish crucial incapacities. The therapist has an important role in the process of self-investigation that can lead to a growing motivation for change. The therapist must stimulate his or her patients to perform an honest introspection, to find realistic solutions for their problems, and to plan an adequate route. The therapist must also prepare his or her patients to adapt to growth and manage related risks of crisis and relapse. Furthermore, shame felt as a result of unmasking the real self must be linked to the patient's therapy and limited to former attempts of self-denying and self-hate. A therapist should avoid patients' inclinations to generalize shame onto their whole person.

Investigation of Instinctual Drives, Unconscious Desires, Incapacities, and Activities That Form the Basis of Narcissistic Shame

This article asserts that shame is the result of a conflict between unconscious drives and desires, self-conscious emotions (such as guilt and empathy), and cognitive func-

tions. Investigation of the precise conflict between conscious and unconscious forces might lead to insight concerning the core problem of the patient. For instance, due to internalized high expectations of a mother figure in the past, a person desperately desires excessive attention. When he or she is incapable of drawing attention in a normal manner by showing his or her real character and capacity, he or she may provoke excessive attention from other persons by utilizing his or her false self and simulating his or her uniqueness, resulting in shame (because the real self did not garner this attention). During the psychotherapeutic process, patients can obtain insight to this intrapsychic conflict. Even more important, patients can learn to find out what their healthy aspirations and desires are—aspirations and desires that fit their character and abilities—and how these can be fulfilled. Of course, the psychotherapist must keep an eye on and stimulate the patient's sense of reality during this process. Moreover, since shame is not tolerated by narcissists, they will try at all costs to suppress it with a very rigid, selfish, fearful, and hostile attitude that will provoke relational and emotional problems. In therapeutic settings, this destructive intrapsychic mechanism should be investigated and analyzed in order to obtain the insight, information, and strength that is necessary to realize improvement.

Stimulation of Moral Activity and Self-reflection

Because of their selfish attitude, patients with NPD demonstrate moral underdevelopment and lack moral emotions such as empathy. This process of moral development can be guided by means of spiritual psychotherapy (see Martens, 2003) and ethics therapy (see Martens, 2001a), therapies that are specially developed for patients with severe personality disorders. Moral and empathic maturation can contribute significantly to their recovery and the normalization of their relationships with the outside world.

"Masking and defending vulnerability is such a destructive form of self-denial and so energy-consuming that it makes the patient weak, exhausted, and even more vulnerable."

Transformation of Negative Emotions into Positive Emotions

Severe aggressive impulses linked to the shame-anger mechanism can be transformed into social-emotional constructive forces by means of agitation therapy (see Martens, 2001b) that is specially developed for patients with severe personality disorders. During the therapeutic process patients can learn to use the constructive correlates of shame (increase of self-insight, reality testing, and social/emotional and moral awareness). During therapeutic sessions with controlled acting-out learning moments, they will develop a more mature and acceptable social-emotional attitude.

Therapeutic Humor

The use of therapeutic humor can contribute to a growth of social-emotional and moral awareness and capacities, enhancement of self-insight and reality testing, and associated therapeutic progress in patients with severe personality disorders (Martens, 2004). Therapeutic humor can be a unique tool for communication, discovering hidden drives and motives, and revealing the truth; correction and growth of self-insight; and elimination of undesirable conditions.

Communication, Discovering Hidden Drives and Motives, and Revealing the Truth

Through humorous paradox or exaggeration, patients often reach a discovery regarding their core problem and intrapsychic world. For this purpose, therapeutic humor should be directed toward disclosure and making suspected unconscious deviant patterns in narcissistic patients less harmful. For instance, unconscious and suppressed feelings of shame, inferiority, and insecurity that correlate with arrogant and hostile behavior might be brought into the patient's awareness in a subtle and humorous manner. Such insight could form the basis of the patients' self-humor and self-criticism as well as associated enhancement of self-insight, motivation for change, and necessary social-emotional and/or moral development.

Correction and Growth of Self-Insight

Adequate use of humor might also correct the patients' innate capacity for social and moral emotions such as empathy by detaching them from their selfish and hostile attitude. It is however, important that therapists use appropriate humor for the development of emotional abilities and that the humor includes emotional and social learning moments (easy, accessible humor that requires an empathic or other emotional attitude of the patient). The

therapeutic use of humor with social learning moments should provide insight in the profits of social adjustment and should be intended to increase social awareness and readiness for adjustment.

Elimination of Undesirable Conditions

Therapeutic humor might contribute to a reduction of aggression when it is directed toward the transformation of destructive impulses and hidden forces into socially acceptable drives. Patients can be motivated to change by providing humorous material for introspection; it can also help them discover the origins and ridiculous aspects of excessive aggression. The therapeutic use of humor can also help patients put negative and hostile thoughts out of their minds by making them aware of the fact that their anger is excessive and disproportionate. It can also help make patients aware of the consequences of an aggressive and negative attitude for their own development, that many people subject to their negative and aggressive thoughts did not provoke such behavior, and that there are strategies to decrease such harmful mental activities.

Conclusion

NPD is characterized by significant contrasting features that are therapeutically relevant.

• Consistent and long-lasting avoidance of shame contrasts with serious vulnerability. Vulnerability is coupled with the processing of contrary emotional and mental conditions such as pride, rage, and anger that should mask and defend against shame. During weak points of this process, experiences of shame, emptiness, and some awareness of one's vulnerability might emerge. Masking and defending vulnerability is such a destructive form of self-denial and so energy-consuming that it makes the patient weak, exhausted, and even more vulnerable.

• Denial of real self and of substantial dimensions of external and internal reality (which are in contrast with the patient's feelings of grandiosity, pride, and vanity) and incapacity to cope with reality are contrasting features.

• Lack of authenticity (as a result of denial of real self), lack of contact with the emotional self (and correlated lack of empathy and emotional shallowness), and lack of contact with the moral self (and related egocentricity and lack of moral capacities) are all in contrast with arrogance and pride. These are the consequences of falling in love with the false self and associated illusionary feelings of superiority that often lead to the devaluation of others.

• Remarkable envy, feelings of fear (Beck & Freeman, 1990), psychological fragility (McWilliams, 1994), and feelings of grandiosity are all contrasting features.

More research is needed into the conflicting dimensions (excessive pride, self-esteem, and vulnerability) of NPD. The neurobiological, genetic, psychosocial, intrapsychic, cultural (aspects of honor, loyalty, revenge, pride), religious, and ethnic correlates of the shame-rage mechanism must also be studied more profoundly. This might enhance insight into the shame-rage mechanism in NPD that is necessary for the construction of more adequate treatment and assessment programs for distinctive categories of narcissistic patients.

References

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.).* (DSM-IV). Washington, DC: APA.

Anastasopoulos, D. (1997). Shame in psychotherapy with adolescents. *Journal of Child Psychotherapy, 23*(1), 103-123.

Barrett, K. (1995). A functionalist approach to shame and guilt. In J.P. Tangney & K.W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride.* New York: Guilford Press.

Batson, C. D. (1987). Prosocial motivation: Is it ever truly altruistic? In L. Berkowitz (Ed.), *Advances in experimental social psychology* (Vol. 20, pp. 65-122). New York: Academic Press.

Baumeister, R. F., Stillwell, A. M., & Heatherton, T. F. (1994). Guilt: An interpersonal approach. *Psychological Bulletin, 115,* 243-267.

Beck, A.T., & Freeman, A. (1990). *Cognitive therapy of personality disorders.* New York: The Guilford Press.

Broucek, F. J. (1991). *Shame and the self.* New York: Guilford.

Brown, J., & Weiner, B. (1984). Affective consequences of ability versus effort ascriptions: Controversies, resolutions, and quandaries. *Journal of Educational Psychology, 76,* 146-158.

Bushman, B.J., & Baumeister, R.F. (1998). Threatened egotism, narcissism, self-esteem, and direct and displaced aggression: Does self-love or self-hate lead to violence? *Journal of Personality and Social Psychology, 75,* 219-229.

Buss, A. H. (2001). *Psychological dimensions of the self.* Thousand Oaks, CA: Sage.

Campbell, W. K. (1999). Narcissism and romantic attraction. *Journal of Personality and Social Psychology, 77,* 1254-1270.

Campos, J. J. (1995). Foreword. In J. P. Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. ix-xi). New York: Guilford.

Cooper, A. M. (1998). Further developments in the clinical diagnosis of narcissistic personality disorder. In E. F. Ronningstam (Ed.), *Disorders of narcissism: Diagnostic, clinical, and empirical implications.* (pp. 53-74). Washington, DC: American Psychiatric Association.

Covington, M. V., & Omelich, C. L. (1981). As failures mount: Affective and cognitive consequences of ability demotion in the classroom. *Journal of Educational Psychology, 73,* 796-808.

Doosje, B., Branscombe, N. R., Spears, R., & Manstead, A. S. R. (1998). Guilty by association: When one's group has a negative history. *Journal of Personality and Social Psychology, 75*(4), 872-886.

Einstein, D., & Lanning, K. (1998). Shame, guilt, ego development, and the Five-Factor Model of personality. *Journal of Personality, 66*(4), 555-582.

Farwell, L., & Wohlwend-Lloyd, R. (1998). Narcissistic processes: Optimistic expectations, favorable self-evaluations, and self-enhancing attributions. *Journal of Personality, 66,* 65-84.

Fischer, K. W., & Tangney, J. P. (1995). Self-conscious emotions and the affect revolution: Framework and overview. In J. P. Tangney & K. W. Fischer (Eds.), S*elf-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (pp. 3-24). New York: Guilford.

Gramzow, R., & Tangney, J. P. (1992). Proneness to shame and the narcissistic personality. *Personality and Social Psychology Bulletin, 18*(3), 369-376.

Greenwald, A. G. (1980). The totalitarian ego: Fabrication and revision of personal history. *American Psychologist, 35,* 603-618.

Grosch, W. N. (1994). Narcissism: Shame, rage and addiction. *Psychiatric Quarterly, 65*(1), 49-63.

Harder, D. W., Cutler, L., & Rockart, L. (1992). Assessment of shame and guilt and their relationships to psychopathology. *Journal of Personality Assessment, 59,* 584-604.

Harvey, J. H., & Weary, G. (1984). Current issues in attribution theory and research. *Annual Review of Psychology, 35,* 427-459.

Izard, C. E. (1971). *The face of emotion.* East Norwalk, CT: Appleton-Century-Crofts.

Jagacinski, C. M., & Nicholls, J. G. (1984). Conceptions of ability and related affects in task involvement and ego involvement. *Journal of Edu-*

cational Psychology, 76, 909-919.

John, O. P., & Robins, R. W. (1994). Accuracy and bias in self-perception: Individual differences in self-enhancement and the role of narcissism. *Journal of Personality and Social Psychology, 66,* 206-219.

Kahn, W., Oppenheimer, C., Martens, W. H. J. (2004, June 12). *Results of agitation therapy, spiritual psychotherapy and ethics therapy in 60 violent patients with severe antisocial and narcissistic personality disorder.* Paper presented at the 2004 Conference on Theoretical Psychiatry and Psychotherapy, Elst, Utrecht, of the W. Kahn Institute of Theoretical Psychiatry and Neuroscience, Netherlands.

Kaufman, G. (1980). *Shame, the power of caring.* Rochester, VT: Schenkman.

Kaufman, G. (1989). *The psychology of shame.* New York: Springer.

Kernis, M. H., Cornell, D. P., Sun, C., Berry, A., & Harlow, T. (1993). There's more to self-esteem than whether it is high or low: The importance of stability of self-esteem. *Journal of Personality and Social Psychology, 65,* 1190-1204.

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Kohut, H. (1971). *The analysis of the self.* New York: International Universities Press.

Kohut, H. (1972). Thoughts on narcissism and rage. *Psychoanalytic Study of the Child, 27,* 360-400.

Kohut, H. (1977). *The restoration of the self.* New York: International Universities Press.

Lee, R. (1995). Gestalt and shame: The foundation for a clearer understanding of field dynamics. *British Gestalt Journal, 4,* 14-22.

Lee, R., & Wheeler, G. (1996). *The voice of shame.* San Francisco: Jossey-Bass.

Lewis, H. B. (1971). *Shame and guilt in neurosis.* New York: International Universities Press.

Lewis, M. (2000). Self-conscious emotions: Embarrassment, pride, shame, and guilt. In M. Lewis & J. M. Haviland-Jones (Eds.), *Handbook of emotions* (2nd ed., pp. 623-636). New York: Guilford.

Martens, W. H. J. (2001a). A theoretical framework of ethics therapy as a distinctive therapeutic specialization. *International Journal of Offender Therapy and Comparative Criminology, 45*(2), 383-394.

Martens, W. H. J. (2001b). Agitation therapy for antisocial and psychopathic personalities: An outline. *American Journal of Psychotherapy, 55*(2), 234-250.

Martens, W. H. J. (2003). Spiritual psychotherapy for antisocial and psychopathic personalities. *Journal of Contemporary Psychotherapy, 33*(3), 205-218.

Martens, W. H. J. (2004). Therapeutic use of humor in antisocial personalities. *Journal of Contemporary Psychotherapy, 34*(4), 351-361.

McWilliams, N. (1994). *Psychoanalytic diagnosis, understanding personality structure in the clinical process.* New York: The Guilford Press.

Millon, T., & Davis, R. (1996). *Disorders of personality DSM-IV and beyond.* New York: John Wiley & Sons.

Morf, C. C., & Rhodewalt, F. (2001). Unraveling the paradoxes of narcissism: A dynamic self-regulatory processing model. *Psychological Inquiry, 12,* 177-196.

Morrison, A. P. (1983). Shame, ideal self, and narcissism. *Contemporary Psychoanalysis, 19*(2), 295-318.

Morrison, A. P. (1989). *Shame: The underside of narcissism.* Hillsdale, NJ: Analytic Press.

Morrison, A. P., & Stolorow, R. D. (1997). Shame, narcissism, and intersubjectivity. In A. P. Morrison, & M. R. Lansky (Eds.), *The widening scope of shame* (pp. 63-87). Hillsdale, NJ: Analytic Press, Inc.

O'Leary, J., & Wright, F. (1986). Shame and gender issues in pathological narcissism. *Psychoanalytic Psychology, 3*(4), 327-339.

Oldham, J. M., Morris, L. B. (1990). *The personality self-portrait, why you think, work, love, and act the way you do.* New York: Bantam Books.

Richards, H. J. (1993). *Therapy of the substance abuse syndromes.* Northvale, New Jersey: Jason Aronson Inc.

Robins, R. W., Tracy, J. L., & Shaver, P. R. (2001). Shamed into self-love: Dynamics, roots, and functions of narcissism. *Psychological Inquiry, 12,* 230-236.

Scheff, T. J. (1998). Shame in the labeling of mental illness. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 191-205). Oxford, England: Oxford University Press..

Scheff, T. J., Retzinger, S. M., & Ryan, M. T. (1989). Crime, violence, and self-esteem: Review and proposals. In A. M. Mecca, N. J. Smelser, and J. Vasconcellos (Eds.), *The social importance of self-esteem* (pp. 165-199). Berkeley, CA: University of California Press.

Sperry, L., & Carlson, J. (1993). *Psychopathology and psychotherapy, from diagnosis to treatment.* Philadelphia, PA: Accelerated Development, Inc.

Tagney, J.P., Burggraf, S.A., & Wagner, P.E. (1995). Shame proneness, guilt-proneness, and psychological symptoms. In J.P. Tagney & K.W. Fisher (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride.* New York: Guilford Press.

Tangney, J. P., & Dearing, R. L. (2002). *Shame and guilt.* New York: Guilford.

Tangney, J. P., Miller, R. S., Flicker, L., & Barlow, D. H. (1996). Are shame, guilt, and embarrassment distinct emotions? *Journal of Personality and Social Psychology, 70,* 1256-1269.

Tangney, J. P., Wagner, P., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101,* 469-478.

Tracy, J. L., & Robins, R. W. (2002). *Guilt, shame, and pride: An appraisal theory perspective.* Poster session presented at the third annual meeting of the Society for Personality and Social Psychology, Savannah, GA.

Tracy, J. L., & Robins, R. W. (2003b). "Death of a (narcissistic) salesman": An integrative model of fragile self-esteem. *Psychological Inquiry, 14,* 57-62.

Tracy, J. L., & Robins, R. W. (2004a). Putting the self into self-conscious emotions: A theoretical model. *Psychological Inquiry, 15*(2), 103-125.

Tracy, J. L., & Robins, R. W. (2004b). Keeping the self in self-conscious emotions: Further arguments for a theoretical model. *Psychological Inquiry, 15*(2), 171-177.

Watson, P. J., Hickman, S. E., Morris, R. J. (1996) Self-reported narcissism and shame: Testing the defensive self-esteem and continuum hypotheses. *Personality and Individual Differences, 21*(2), 253-259.

Weiner, B. (1985). An attributional theory of achievement motivation and emotion. *Psychological Review, 92,* 548-573.

Wheeler, G., & Jones, D. (1996). *The voice of shame.* San Francisco, CA: Jossey-Bass.

Wink, P. (1991). Two faces of narcissism. *Journal of Personality and Social Psychology, 61*(4), 590-597.

Wright, P.M., Lichtenfels, P.A., & Pursell, E.D. (1989). The structured interview: Additional studies and a meta-analysis. *Journal of Occupational Psychology, 62,* 191-199.

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