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The Minor Differences of Narcissism: Narcissistic Personality in Germanophone Europe and North America
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Doctor of Philosophy (PhD) in Sociology
The University of Edinburgh
2016
I, Carl Florian Denig, confirm that this thesis, submitted to the College of Humanities and Social Sciences at the University of Edinburgh in partial fulfilment of the requirements for the degree of Doctor of Philosophy in Sociology, has:

i) been composed solely by myself;

ii) been wholly the result of my own work (except where explicitly stated otherwise in the text), and

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Carl Florian Denig

Date

Edinburgh, Scotland
ABSTRACT

How can the same object become split when viewed by different groups of observers? What is the relationship between conflict and consensus, and the ritual and the rational? I interrogate these questions through the case of narcissistic personality disorder (NPD) in Germanophone Europe and North America.

I interviewed forty-five practitioners from Germany, Austria, Switzerland, the US and Canada. These conversations were semi-structured and ethnographically inflected. I attempted to take the informant’s perspective earnestly and to read any available works by that author in advance of the interview. To gain a sense of how science differed when not immediately concerned with the treatment of patients, I included an assessment specialist and a social-personality psychologist. Non-expert practitioners, who had not published any books or articles on pathological narcissism, were included to test whether theory is solely alluring to the academician or if it holds sway over the psychotherapist on the street. These respondent pools were matched as closely as possible across the two contexts to facilitate comparison. Approximately six psychotherapeutic schools emerged as important amongst my respondents.

After a brief introduction to the different psychotherapies, I begin with the native understandings of NPD or pathological narcissism. These definitions and the wide range of narcissistic patients seen pose the puzzle: How can these definitions be so disparate, and all ostensibly be concerned with NPD as a clinical or scientific object? My concern is less oratorical and more earthy: What precisely do practitioners do? Opening with assessment (Ch. 5), we find some common signs. Diagnostic procedures may employ different technological mixes, but ultimately all follow a single pattern. Chapter 6 addresses empathy and the therapeutic alliance. The notion of a minimal medical model underlying all treatment types I encountered was unearthed despite many methods’ active denial of the ‘medical model.’ The patient-practitioner boundary is, however, far from the final frontier. Conceptualisation helps to guide the ways in which clinicians interact with one another, and ultimately the broader science of psychopathology. Chapter 8 addresses the ways in which different classificatory schemes relate to one another, and how this helps to shape the science of narcissism.

What ultimately emerges is a story of (1) the minor differences of narcissism and (2) the narcissism of minor differences. The narcissism (2) can be said to obscure the (1) minor differences. Competition is inherent in the process at multiple levels: between models for both students and patients (attention-space), and through scientific exchange and the effort to gain evidence for one’s theory. I suggest that science serves less to find the best description or explanation for pathological narcissism, and more to legitimate one’s conceptualisation. Evidence of this sort gives a theoretical school means to command more financial and attentional resources. Psychotherapeutic technology is, however, path dependent, limiting the distance between any two methods.
Two unique theoretical contributions are made, a model of psychotherapeutic diagnosis, and the concept of the minimal medical model. Commonalities amongst all treatment types I studied led me to schematise diagnosis as 5 D’s: discovery, distinction, discussion, dispersion, and direction. In examining how my respondents dealt with the oft vilified (and rarely defined) medical model, a minimal medical model crystallised. The schema, which most of my informants adhered to, is tripartite:

1) confidence that specific psychological suffering or dysfunction can be detected through their school’s technologies, and is knowable,
2) a belief in manifold specific aetiologies thus allowing the clinician to intervene appropriately in these disorders, and
3) comprehension of the disorder’s course and an ability to give a patient’s prognosis

Through its comparative component, this study joins a still sprouting literature in sociology and anthropology investigating similarities and differences in Western psychotherapy and medicine.

Overall, narcissism appears to be a continuum which has different cut points for different theoretical traditions. A clinician’s conceptualisation of narcissism serves as both a scientific and clinical lens, and a means of generating solidarity not just amongst practitioners but also between patients and providers. Examining the details of therapy-as-interaction moves us beyond facile explanations such as labelling and social control. Being flexible enough to allow inter-tradition communication is the Diagnostic and Statistical Manual of Mental Disorder’s greatest success and shortcoming simultaneously. An intellectual technology, including an aetiology, is what allows theory-laden psychotherapy to sell itself and treatment to proceed. Being atheoretical is thus prize and problem simultaneously. To my knowledge, this study represents both the first sociological investigation of NPD and the first attempt to bridge technological and relational understandings of psychotherapy. Models are uncomfortably alike, but must stand out to succeed. We see here the intertwining of the ritual and the rational, the technological and the relational, and as Davies (2009: 228-232) would suggest, identification and differentiation.
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ACRONYMS AND ABBREVIATIONS

AAI Adult Attachment Interview
APA American Psychiatric Association
CBT Cognitive-Behavioural Therapy
COP Clarification-Oriented Psychotherapy (*Klärungsorientierte Psychotherapie*)
DBT Dialectical Behaviour Therapy
DDX Differential diagnosis
DSM Diagnostic and Statistical Manual of Mental Disorders
DSM-III (R) Third edition (Revised)
DSM-IV (TR) Fourth edition (Text revision)
DSM-5 Fifth edition
ICD International Classification of Diseases
ICD-10 Tenth edition
IIP Inventory of Interpersonal Problems
IPDE International Personality Disorder Examination
IRT Interpersonal Reconstructive Therapy
KVT Kognitive Verhaltenstherapie (German for CBT)
MCMI Millon Clinical Multiaxial Inventory
MM Medical Model
MMM Minimal Medical Model
MMPI Minnesota Multiphasic Personality Inventory
NIMH National Institutes of Mental Health
NOS Not otherwise specified
NPI Narcissistic Personality Inventory
OPD Operationalized Psychodynamic Diagnosis
PAI Personality Assessment Inventory
PBQ Personality Beliefs Questionnaire
PD Personality Disorder
PDM Psychodynamic Diagnostic Manual
PDQ(-4) Personality Diagnostic Questionnaire (Fourth edition)
PNI Pathological Narcissism Inventory
RDoC Research Domain Criteria
SASB Structural Analysis of Social Behaviour
SCID-II Structured Clinical Interview for DSM-IV Axis II Personality Disorders
SINS Single Item Narcissism Scale
SNAP Schedule for Non-adaptive and Adaptive Personality
ST Schema Therapy
STIPO Structured Interview for Personality Organisation
TFP Transference-Focused Psychotherapy
VT Verhaltenstherapie
WHO World Health Organisation
YCI Young Compensation Inventory
YPI Young Parenting Inventory
YRAI Young-Rygh Avoidance Inventory
YSQ Young Schema Questionnaire
“… The last distortion of romance
Forsook the insatiable egoist. The sea
Severs not only lands, but also selves.
Here was no help before reality.”

Wallace Stevens (1997:22), *The Comedian as the Letter C*

“For the personality system, evil resides in the id, while for the social system, it resides in the ego.”

Philip E. Slater (1963:346)

“These days we don't notice other people's selfishness until we're on the receiving end ourselves.”


“Remote and amatory, that style of life
In which no one offends or intrudes.
They might as well live in their wardrobes.”

Douglas Dunn (2003:30), *In the Small Hotel*
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Chapter 1: The Scientific Buffet: Concepts, Conflict, and Self-Interest

Narcissistic personality disorder (NPD) sounds a likely suspect for labelling theory. Given the way we use narcissist in everyday speech, I can see how one might be mistaken. The trek we’ll take is arduous, from diagnosis to treatment to the science of this psychopathology. I conducted semi-structured interviews with forty-five practitioners in Germanophone Europe and North America. Every effort was made to take the informant’s perspective earnestly and to read work by that author before the interview. Some were experts – heads of clinics, authors of highly influential texts and/or articles, inventors of psychological assessment tools, and others ‘pure’ practitioners, the type of clinician a narcissist might be treated by in a mid-sized city. The former sometimes explicitly defined themselves as scientist-practitioners, whereas the latter could be seen more as people simply applying psychotherapeutic technologies. Pure ‘experimentalists’ – a widely regarded social-personality psychologist and an esteemed assessment specialist – were also consulted as it became clear that the triumvirate of competition, self-interest, and conceptualisation also reigned there. My chief question is: How is the content of relational work shaped? Phrased differently, what guides practitioners’ interactions with various parties (e.g. patients, insurers, clinicians, scientists)?

I propose that theory blazes the trail. Competition between conceptual camps is a key component throughout, as they struggle for attentional and financial resources. Science becomes a tool not for understanding narcissism, but for legitimating one’s
theory. Evidence is a spanner, used to pry apart the ribs of historically connected psychotherapies. A tidy summary is that the narcissism of minor differences obscures the minor differences of narcissism. In other words, psychotherapists are often in violent agreement with one another.

This study offers four unique contributions, two theoretical and two empirical. I propose modelling psychotherapeutic diagnosis with 5 d’s: discovery, distinction, discussion, dispersion, and direction. My second conceptual contribution is the idea that psychotherapists attend to aetiology, course, diagnosis, and prognosis even when they claim not to be medical. These traditional medical concerns are summarised in what I call the minimal medical model.

I sought to bridge relational and technological understandings of psychotherapy, using elements from medical sociology/anthropology, science and technology studies, and conversation-analytic studies. This study is, to my knowledge, the first both to attempt this union and to sociologically examine narcissistic personality disorder. Finally, I fertilise two sprouting social scientific literatures, one on personality disorders and the other comparing health care within the West. But are the young sciences I study, with their comparatively crude tools and slow development, homologous with what we typically consider science?

The word science brings complex instruments and continual progress to mind. Put plainly, physics, chemistry, and biology, not psychology or psychiatry. All three are often framed as evolutionary, or at most viewed in their historical relation to one another. The sciences concerned with the human mind, which I’ll refer to
ecumenically as psychiatry, are seen as different in kind from these hard sciences. Early microscopy gives us a point of contrast, allowing the elaboration of some key themes of this study.

I use Antonj van Leeuwenhoek’s life not to perpetuate ‘great man’ models of scientific discovery, but as a convenient referent. A scientist of superlative sobriquets such as the “father of protozoology and bacteriology” (Dobell 1958) is difficult to reconcile with the jealous, closely-guarded man seen below. Indeed, he presents several puzzles: How can someone often praised by biologists seem so selfish? How could such an ‘untrained’ individual using home-made instruments achieve so much?

Hints of competition are manifested in von Uffenbach’s description of his visit (4\textsuperscript{th} December 1710):

“\[T\]hough he had discovered many new things with his \textit{microscopia} in recent years, [Leeuwenhoek] did not wish to publish any more of his observations during his lifetime, because of the affronts he had suffered, presumably in the writings of others; for he has now and then been ridiculed for the odd views expressed in his own writings, and has been accused of seeing more with his imagination than with his magnifying glasses. … Finally, Mr. Leeuwenhoek showed us his cabinet, in which he had at least a dozen little lacquered boxes, and in these quite a hundred and fifty of the little cases before mentioned, in each of which there lay two microscopes of the small sort. As we marvelled at this large store, we asked him whether he had never sold any? as we would gladly have possessed ourselves of some: but he said no, he would sell none in his lifetime. He was also very secret about his work, and how he did it…”

Z.C. von Uffenbach (translated and reproduced in Dobell 1958:64, 67-68)

Competition, in both instances, exists side-by-side with a spirit of shared inquiry (cf.
Collins 2000). Scientists emerge not as dispassionate, but as social, sentimental creatures. Van Leeuwenhoek thus introduces three themes which run throughout the following text: (1) competition, (2) self-interest, and (3) modelling or conceptualisation. Ideas compete in a space where what later becomes taken for granted is scoffed at (“seeing more with his imagination”), because it does not fit with the contemporary conceptions of what science is. Contestation in turn triggers self-interest.

A second-hand description of another visit to van Leeuwenhoek elucidates (Constantijn Huygens junior\(^1\), letter of 5 November 1685, translated and reproduced in Dobell 1958:60-1):

“[Willem Meester (a skilled Dutch mechanic)] had been with [Karl, Landgrave of Hesse-Cassel (1654-1730), an amateur of science] to Leeuwenhoek’s, who wouldn’t show him any of his microscopes except those which he shows to everybody; whereof the little glasses had, at least, a focal distance equal to the width of the back of a knife. And when the Landgrave asked him whether he could obtain some, of his manufacture, he answered with much pride that he never gave any to anybody, nor did he intend to do so: and that if he were ever to submit to that, he would then be the slave of everybody; with other expressions of the like sort. When he had shown two or three of his microscopes, he took them away, and went to look for as many others; saying that he did this for fear lest any of them might get mislaid among the beholders, because he didn’t trust people, especially Germans: and he repeated this two or three times. O what a brute!”

The attributed language, “then be the slave of everybody”, suggests a shrewd comprehension that if he revealed his methods he would be only a technician, whereas secrecy allowed him scientist status. Nor is this self-interest simply an artefact from the dawn of modern science: Even today, according to one solid-state

\(^1\) Parenthetical descriptions are Dobell’s (1958:60).
researcher, omission of key experimental steps from publications is not uncommon to sidestep being scooped (cf. Hagstrom 1965:Ch, II).

International competition, and cultural prejudice in an ostensibly objective observer (Leeuwenhoek’s distrust of Germans), raises the question of national contexts. My own study originally focused on this issue, leading to the choice of these two settings. NPD is split not only by these expectable distinctions, but different official classificatory and diagnostic systems are allegedly adhered to in the two settings. In Germanophone Europe and the bulk of the world, the World Health Organisation’s *International Classification of Diseases (10th ed.,* hereafter ICD-10) is used to distinguish and describe diseases and mental disorders. The American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders 5* (hereafter DSM-5) holds dominion over diagnosis in the land of the free. Vital to this study is the ICD-10’s relegation of NPD to a residual category (F60.9 Other Specific Personality Disorders).

NPD is therefore an officially excluded category in the ICD countries. Alongside this notary neglect, we have also competing accounts of what narcissism is and what counts as valid evidence on NPD. Pathological narcissism therefore offers an almost ideal environment for the study of medicalisation not as a universal power-process imposed from above, but as itself a *conflict-driven*2 process. Theoretical schools emerged as more important because these are trans-national movements. Rafaeli, Bernstein, and Young’s (2011) *Schema Therapy*, for instance, is a collaboration

2 Underlining denotes my emphasis. I reserve italics for foreign terms and emphasis in the original.
between Israeli, Dutch, and American clinicians. These collectives drive debates on what pathological narcissism is and how we ought to treat and collect data on it.

Official recognition and scientific norms were concerns from Leeuwenhoek’s early investigations onward. Henry Oldenburg, first secretary of the Royal Society, suggested to Leeuwenhoek that he “make use of the service of other people, who are in a position to form a proper judgment of such things” (Dobell 1958:46, quoting a 1675 Leeuwenhoek letter to Oldenburg). The ‘father of protozoology’ pointed out that few locals were able to aid him, and continued that “among those who can come to visit me from abroad, I have just lately had one who was much rather inclined to deck himself out with my feathers, than to offer me a helping hand” (ibid). Doubt, faith, self-interest, and conflict swirl about animals whose existence has become taken-for-granted.

What of personality disorder (hereafter PD)? A bacterium is, by comparison, clearly bounded and easily identified. DSM-5 defines PD as:

“[A]n enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.” (APA 2013:645)

The alternative model (APA 2013:761-781) suggests PDs “represent maladaptive variants of personality traits that merge imperceptibly into normality and into one another” (646). We see similar understandings in the Psychodynamic Diagnostic Manual (PDM 2006:19) and ICD-10. PD is a particularly pernicious phrase, and certain informants expressed outright disapproval of this term. Why use it then?
It’s intellectually important to use native terms, and to attempt to understand them as they are used. Sachse’s (2013:12) stipulation is thus shared by this study: “Since this term has become thoroughly ingrained (sich aber weitgehend eingebürgert hat), we can continue to use it because we know what we intend to say with it and what we don’t.” Additionally, I have the audacity to insist that mental illness is indeed a real thing, causes real suffering, and has consequences for the everyday lives of ordinary citizens. Pragmatic and intellectual considerations alike underlie my use of PD.

Finally, let us return to Leeuwenhoek being “ridiculed for the odd views expressed in his own writings, and has been accused of seeing more with his imagination than with his magnifying glasses” (von Uffenbach in Dobell 1958:64). Such accusations evidence the closeness – indeed nigh inseparability (e.g. Kuhn 1996:7) – of theory and data. Furthermore, this statement hints at path dependency in science, and how theory might be detrimental. In the end, knowledge is gained, but it is – as historians and sociologists of science show us – far from a straightforward process (e.g. MacKenzie 1981).

What of Karl Jaspers’ classic distinction of psychopathology and psychiatry, one Wissenschaft and the other Kennerschaft? We see echoes of such a divide in van Leeuwenhoek’s supposed disavowal of “slave” status, his efforts to be a scientist, not an engineer. Psychotherapy (and even pharmacotherapy) are technologies, much like microscopes, which draw upon – in turn influencing – a broader scientific field. My conclusions as to the interconnection of science and technology rests largely on
my own interactions with present-day practitioners.

Experimentalists and engineers see the world differently, and people who occupy both roles hold yet another vantage point. At the core of these sights lays a common object. Their differing gazes place different boundaries on pathological (and so normal) narcissism, but there is something there beheld by all observers. At the core of contention lays some consensus\(^3\), which is often obfuscated by these different conceptual camps.

Theoretical models allow one to sort information, to see a certain way (Fleck 1979:*passim*, especially 94-95, 99). What I call theoretical models roughly equate with Fleck’s (1979) thought styles, “define[d] as [the readiness for] directed perception, with corresponding mental and objective assimilation of what has been so perceived” (99). Different schools within psychiatry allow practitioners to proceed with the business of treating patients and/or researching psychopathology. Each psychotherapeutic tradition is therefore a thought collective, or “a community of persons mutually exchanging ideas or maintaining intellectual interaction” (1979:39). Such a collective “provides the special ‘carrier’ for the historical development of any field of thought, as well as for the given stock of knowledge and level of culture” (ibid). My research addresses the interactions of different thought collectives, and how their thought styles generate “a technical and literary style characteristic of the given system of knowledge” (99).

\(^3\) Suggested by Liliana Riga.
We now survey the path we are to perambulate. Chapter 2 situates my work in science and technology studies (STS), and medical sociology. I trace self-interest, competition, and conceptualisation through diagnosis, treatment, and research. Following Rose (1998:10-11), I use the concept of intellectual technology to analytically distinguish theory from interactional technologies. Theory is found to be inherent in observation. My reevaluation of the conversation analytic literature suggests broad similarities across psychotherapies. I close with science, stressing the coexistence of competition and collaboration. Amalgamation, segregation, and translation are introduced as interaction types utilised by practitioners and theoretical schools.

Chapter 3 covers methodology, beginning with an autobiographical sketch to contextualise my findings. Terminological issues, such as my use of psychiatry in an ecumenical sense, and some international distinctions are further discussed there. Chapter 4 concerns my informants’ various definitions of NPD or pathological narcissism. I also review how respondents talked about related phenomena, such as normal narcissism or narcissistic rage. Beginning here we see the minor differences of narcissism.

Chapter 5 discusses diagnosis as a process, schematising it in 5 D’s: (1) discovery, (2) distinction, (3) discussion, (4) dispersion, and (5) direction. Assessment is a theory-guided process, whereby each stage represents a particular relationship. Concepts order the jumble of a pre-patient's biography, and guide the clinician's hand by providing patterns for the various relationships entailed in diagnosis’ progression.
We find substantial similarities across the psychotherapeutic spectrum despite assessment being arguably the most differentiated relative to science or treatment. In other words, the minor differences of narcissism begin the moment the pre-patient enters the consulting room.

Chapters 6 and 7 concern treatment, beginning with psychotherapy’s problematic relationship with the medical model. I adumbrate how the diverse schools’ approaches fit with or deviate from a medical model, focusing on emotions in the treatment. A minimal medical model is found to underlie most, if not all, the psychotherapies I studied. Chapter 7 concerns four key areas of difference psychotherapists must negotiate: (I) between patient and practitioner, (II) across therapeutic traditions, (III) across a heterogeneous patient pool, and (IV) cross-national differences. Related to but distinct from Chapter 6’s alliance-building is the question of interpersonal distance. While a treatment frame provides one way of doing so, there are many more immediate means of negotiating this bond. The similarities and differences we see there take us into practitioners’ self-perceptions and management of theoretical boundaries. Cross-national differences tend to be more in how narcissism presents, leading us back into (V) treatment indications for various patients with NPD. To some extent we return here to the world of diagnostic-distinction, as there is a shuttling back and forth between intrapersonal and interpersonal variation. Overall, a great many family resemblances, even across the behavioural/psychodynamic divide, emerge.

Chapter 8 examines psychoanalysis’ efforts to evade expulsion before considering
contradictions and strains in psychopathological science. Three basic tensions were raised by my respondents: (a) clinical vs. scientific logic, (b) clinical vs. scientific knowledge, and (c) clinical science vs. clinical experience. We close on classification, specifically dealing with DSM: Different relations to the manual arise, and several competitors (one prominent, the others obscure) vie for clinical and scientific use. This chapter ties together many of the themes dealt with in earlier substantive chapters, and is followed by the conclusions in Chapter 9. In short, theory gives practitioners both a lens and a rough behavioural blueprint for negotiating the various boundaries they face. Conceptualisation simultaneously obscures the deeper similarities, leading to the narcissism of minor differences masking the minor differences of narcissism.

Science is, as one informant put it, the best means we have of finding things out (US-CP-8, 20.08.2013). I don’t disagree, but there is a flaw inherent in the method. No matter if the instrumentation is as simple as a diagnostic interview or as complex as an MRI scanner, it still relies on social, sentimental humans to operate it and interpret results. An exchange between G.K. Chesterton’s (2006:246) Father Brown and an American detective using a ‘lie detector’ humorously highlights our not infrequent blindness to this fact:

“‘…Isn’t that better evidence than a lot of gabble of witnesses – if the evidence of a reliable machine?’
‘You always forget,’ observed his companion, ‘that the reliable machine has to be worked by an unreliable machine.’
‘Why, what do you mean?’ asked the detective.
‘I mean Man,’ said Father Brown, ‘the most unreliable machine I know of.’”
Chapter 2: “Not, then, men and their moments. Rather moments and their men.”

Sociology’s mandate, according to Strong (1979a:201, following Halmos 1973), includes “professional scepticism.” Despite our scepticism and reflexivity, we manage to mostly miss our own imperialistic aspirations (Strong 1979:201-205). We expose ourselves through inattention to colleagues who take psychiatry seriously, for instance, “Lee Robins, a sociologist whose husband Eli Robins was a member of the core group of diagnostically oriented psychiatrists at Washington University” (Horwitz 2002:85). It is – by my understanding – common knowledge that people tend to age out of antisocial behaviour around age 35. But where did this knowledge come from? Robins’ retrospective study of the patients of a child guidance clinic (1974:225-227) acted as a natural history of sociopathic personality and led to this finding.

Frankly, I find tribalism in social science silly, as it leads to the narcissism of minor differences at home. Theses must however be classed, and the doctoral candidate lumped into a category. My literature choice may seem random – indeed, a supervisor commented thusly on an earlier draft. Given the lack of a bespoke sociological literature on PDs, I draw widely from STS (in particular the sociology of scientific knowledge), conversation analytic studies of psychotherapy, and medical sociology and anthropology. Inherent in this mix are three assumptions: 1)
psychiatry is a science like any other, 2) the application, creation, and extension of psychotherapeutic technologies is much the same as with more tangible technologies, and 3) insights from one subfield or discipline are portable to another.

To develop a sociological account of a phenomenon that is equally clinical and scientific, we must build a harmony and therefore blend voices. My study’s key finding is that boundaries are overstated in psychiatry and prevent knowledge from accumulating there – why, then, would I want to repeat the same mistake in my own field?

I begin by developing my relational and ethnographic-integrative theoretical framework, which acknowledges that “[p]sychiatry is a science, a technology and a profession” (Manning 2000:634). From here, I review the relevant empirical and theoretical contributions to the study of diagnosis and assessment, psychiatric treatment, and science. Our progress here parallels that of the thesis itself, moving from intellectual to interactional technologies, and closing with the broader scientific field.

Zelizer’s (2012) understanding of relational work has guided my thinking throughout the writing process. Social relations are bounded by “names and practices”, with shared understandings inside the boundary, and certain media for and types of cross-boundary interactions marked as appropriate (ibid:146). I am concerned with relational work at several overlapping boundaries (cf. Schegloff 1963:63 for a similar consideration of dynamic psychotherapy alone), including between therapeutic
schools, patient/practitioner, research/clinic, and therapeutic school/research. All four elements of Zelizer’s (2012:151) “relational packages” are relevant, which “consist of combinations among (a) distinctive interpersonal ties, (b) economic transactions, (c) media, and (d) negotiated meanings.” While economic considerations inevitably creep their way in from time to time, my focus remains on the other three.

I treat diagnostic and other intellectual technologies (e.g. the model used in schema therapy) as media. These cannot be said to be actors, but are more than props in a Goffmanian performance – in a way they help to ‘constitute’ the psychotherapeutic encounter. Much like “monetary media and economic practices,” these interactional media and therapeutic practices “emerge as eminently flexible adaptations to multiple social ties” (163). Zelizer (ibid), like Rosenberg (2015, esp. 133-135), underscores that this creativity must relate to power and therefore is subject to contestation (cf. Collins 2000:42-46 on stratification in intellectual communities and individuals). My aim is largely descriptive, and seeks to answer the question: How is the content of relational work regarding pathological narcissism shaped?

Beyond this broadly relational framework, there are two other legs to the stool. Diagnostic systems (e.g. Pickersgill 2012a) and measures, as well as the “stocks of interactional knowledge” (Peräkylä & Vehviläinen 2003) conveyed by supervision and treatment manuals are all treated as technologies. I rely here on Rose’s (1998:10-11) concept: “not a body of abstracted theories and explanations, but an ‘intellectual technology’, a way of making visible and intelligible certain features of
persons, their conducts, and their relations with one another.” We therefore have two technological\textsuperscript{4} types in play: intellectual and interactional.

The final flange might be termed an ethnographic-integrative perspective. Most influential in this framework is Horwitz (2002; cf. Horwitz & Wakefield 2007). His position affirms both psychiatric and sociological understandings: “Mental disorders always have culturally specific as well as universal components: mental disorders are internal dysfunctions that a particular culture defines as inappropriate” (2002:12). Following Cullen (1983), structuring is how “the symbolic systems of culture channel the highly generalised manifestations of stress into culturally specific and culturally recognised entities” (114-115). Horwitz modestly claims many DSM disorders are culture bound (116), if the theory holds.

I find Horwitz’ position moderate and in line with the evidence. Wakefield’s (1992) definition of mental disorder contains both moral (judging what is harmful) and scientific (ascertaining what individual dysfunction is, given the evolutionary history of a particular mental mechanism) elements. Horwitz hews closely to this: “Mental disorders are thus socially inappropriate psychological dysfunctions, which either emerge independently of social stressors or persist with disproportionate severity and duration after the stressors that gave rise to them have disappeared” (Horwitz 2002:36). As both sociologist and patient, I find that this captures the experience. Mental illness, diagnosis, treatment, science, and humans are situational – to varying degrees, but context commands us all.

\textsuperscript{4} I take a social worlds (Strauss 1978) approach, where technology is quite simply “inherited or innovative modes of carrying out the world’s activities” (122).
From here, we parallel the thesis’ structure, moving from diagnosis to treatment, closing with science. All these processes are highly contextual and marked by varying degrees of self-interest, competition, and conceptualisation. Elements of all stages are also ritualised. I hope to demonstrate that these three are mutually interdependent. Diagnosis draws on an intellectual technology, and this conceptualisation leads to a particular set of interactional strategies. Treatment feeds back into diagnosis, and these interactional technologies are often standardised to allow for scientific comparison. Finally, science legitimates and often alters the intellectual and interactional technologies deployed by a theoretical tradition. Overall, the process is driven by competition, meaning that science itself is not purely rational. We begin with diagnosis and thus with conceptualisation.

(I) Psychiatric Sight, or an Introduction to Intellectual Technologies

Sociologists are, to a point, perverse: many love nothing more to than to unmask, discredit, or expose others. We revel in highlighting others’ hypocrisy, but fail to realise that although the emperor has no clothes, we too are naked. More interesting to me are commonalities across fields of inquiry. One difference between sociologists and psychiatric professionals is that we are exhibitionistic, showing our intellectual technology to any and all passers-by. It might be said that we diagnose as much as they do, only we’re far less careful about it. Therefore, in examining how intellectual technologies are operated in other fields, we might learn to better wield our own.
Questioning how psychiatric diagnosis is actually done and the role of intellectual and interactional technologies in this process is not merely an esoteric endeavour. Unlike how many angels are on the head of a pin, we can find clues scattered throughout the social scientific literature, yielding three guiding insights. Diagnosis is, like scientific thinking overall, contextual. Secondly, it’s a process, not a moment. Studies of medical education (Atkinson 1997; Light 1980; Luhrmann 2000) and psychoanalytic training (Davies 2009) demonstrate how this way of seeing is ingrained in diagnostic systems and other intellectual technologies. Lastly, then, diagnosis teaches a way of seeing, and this sight is inescapably theory-laden. I use the phrase ‘psychiatric sight’ to convey its breadth and depth. Assessment is a recursive process, happening continually throughout treatment: “By talking to patients, [consultant] psychiatrists also regard diagnosis as a part of therapy and therapy as a part of diagnosis, an interdependence usually not explicitly recognised by nonpsychiatric physicians” (Johnson 1985:274). Due to this circularity and the incorporation of prognosis in psychiatric sight, I deploy this neologism.

(I.1) “Not, then, men and their moments. Rather moments and their men.”

We might slightly pervert Goffman (1967:3) to convey the contextual, situational nature of psychiatric assessment: “Not, then, diagnoses and their moments. Rather moments and their diagnoses.” Diagnosis is dependent upon history (in more than one sense, cf. Gaines 1992b, Rosenberg 1989, Shorter 2013), local and national contingencies, and even individual factors such as theoretical orientation.
These factors often overlap, as shown in a study of staff treating alcoholic in-patients (Frick et al. 1988). Therapists in depth-psychological and behavioural roles found PD and severity of addiction were predictive of prognosis (221). Did they mean the same thing, however? Frick and colleagues attempted to use a patient’s score on either the Freiburger Persönlichkeitsinventar (FPI) or Unsicherheitsfragebogen (UFB) to predict the individual’s PD score. Only two scales were predictive. The “feelings of guilt” scale on the UFB was however significantly and negatively (r=−0.20) correlated. Additionally, the FPI sociability (Geselligkeit) scale did predict (r=−0.25) PD scores for the behavioural role. “Severity in the learning-theoretic understanding depends decidedly on the depth of the present symptomatic (amount of alcohol consumed), while analytic understanding rather used the previous treatment resistance” (222). The same intake anamnesis variables yield different understandings when therapists utilise different types of therapy. Uniquely, Frick et al. (1988) studied not devotees of different methods, but individuals who rotated between treatment types associated with a particular theoretical model. Psychiatric sight, then, was able to shift in the same individual dependent upon the role they were assigned.

Vallée’s (2011) comparison of French and American approaches to ADHD appears to be one of few studies comparing Western approaches to psychiatric diagnoses. The DSM and the Classification Française de Troubles Mentaux d’Enfants et d’Adolescent (CFTMEA) differ in how broadly they construe the symptoms, with French psychiatry having the more restrictive definition. He suggests that increased
focus on context in France leads them to diagnose fewer cases of ADHD (98). A psychodynamic theoretical orientation marks the CFTMEA, and he argues the DSM is biological. While I disagree with his classification of the DSM, Vallée suggests “…theoretical differences can impact what an illness is attributed to and how it will be addressed” (89). Two of his conclusions are relevant here: that “what counts for illness can vary greatly country to country” (101), and his “analysis suggests classification systems should also be considered ‘culture-bound’” (102). Broadly speaking, he is correct. Theory, however, is not constricted by national boundaries, and as we shall see, there is substantial intranational variation in relationship to “[d]iagnostic reference manuals” and sequelae such as “(1) illness prevalence rates, (2) who qualifies for a medical diagnosis, and (3) who will get access to medical care resources” (88).

Diagnosis is also vulnerable to contingency and local demands (Rhodes 1991:93-102; Shaw 2004:1043). Charts often exist independently of the patient, often to the practitioners’ advantage (95-9, 108-16). Antisocial PD was used strategically in a Greek context to keep Roma from claiming full disability (Davis 2010:142; cf. Loring & Powell 1988 on racial and gender effects on US diagnosis), but treatment remained the same (145). Goffman (1961a:360), like Rhodes (1991:93-102), suggests diagnoses draw upon observations in a wholly artificial environment and are largely a bureaucratic, not medical, mandate. Lester (2009:291-292) points us to a patient, Caroline, caught between such contexts. The psychodynamically-oriented eating disorder clinic (with its notions of “epistemic authenticity,” 288-289) wanted to keep treating Caroline. Since she was “not sick enough in the right way” (i.e. “3
months into her treatment, she went 17 days without bingeing or purging”), the managed care organisation (MCO, with its principle, “procedural authenticity,” 289) wanted to discharge her. Borderline had the same lexical meaning in both places, but incompatible symbolic meanings across the boundary. The MCO saw borderline as “not contiguous” with her eating disorder. Since the former was “untreatable” and the latter ‘cured’, there was no legitimate reason to continue paying for treatment (291-292). Psychodynamic understandings hold that surface symptoms may change or recede, but if the deeper problems are unresolved, the patient will continue to be symptomatic. Borderline PD is, in this understanding, inseparable from the eating disorder (292), whereas for the MCO these are entirely separate. The different understandings of BPD generate two distinct ways of relating to Caroline. We see this also in individual clinicians, who have various strategies for sharing (or not) a BPD diagnosis (Sulzer et al. 2015:3). Sulzer and colleagues (2015) doesn’t explain what differentiates the types of strategists, but what matters is that the diagnosis given is understood to have repercussions for how the patient relates to self and others. Diagnoses can therefore also be said to create context.

Hacking (2001:31; cf. Rosenberg 1989:10; Hahn & Kleinman 1983) cautions that “[w]ays of classifying human beings interact with the human beings who are being classified.” This caveat is complemented by his reminder that these interactions “happen within matrices, which include many obvious social elements and many obvious material ones” (ibid). Howard’s (2008) study of “delabelers” underscores how deeply illness identities may root, leading even to a deserter complex (183-5) or a fear of reverse stigmatisation by one’s ex-community (185-186). An
anthropological case study (Lachicotte 2002) suggests that diagnoses become interactional resources, differently deployed to meet the needs of the moment. Borderline PD even became a way for this patient to regain a sense of control and hope (59). What this suggests is that patients aren’t simply passive acceptors of labels, but that they (may) recognise both the pluses and minuses a ‘label’ offers. It is situational and malleable, rather than static. On a more macro scale, classificatory schemes (and changes therein) create context. Shifts in DSM taxonomy twist diagnostic processes by altering how clinicians approach symptoms (Gaines 1992b:7-10).

Dobransky (2009, 2011) demonstrates the uses informal classifications can have. Like Light’s (1980:177-179) managerial and therapeutic diagnoses, the informal categories of “severely mentally ill” or not guided the staff’s relationship to patients in the community mental health centres he studied. His discussion of PDs (2011:122-124, 126) merits special attention as it demonstrates how informal diagnoses can have greater impact than their official kin. Recipients of the informal “not severely mentally ill” tag at both Dobransky’s fieldsites were regarded as having PDs regardless of their official diagnosis (e.g. “‘combined [PD],’ histrionic and borderline” rather than bipolar, 123). He reports that “even though workers saw Rodney’s behaviour as possibly the result of a [PD], and thus looped his disruptive behaviour, they nonetheless thought he had much more control over his behaviour than others had, and thus applied exclusionary social control” (126). Dobransky’s findings suggest that an official diagnosis tends to serve bureaucratic functions,

5 Goffman (1961a:35-36) defines looping as the process of an institution provoking a reaction, and then attacking that response as if it were situationally unjustified, i.e. the result of their illness. It is “a disruption of the usual relationship between an individual actor and [their] acts” (35).
whereas informal ‘labels’ serve local, institutional purposes (127-129). He concludes (2009:728) that “staff’s informal labels of mental illness were based on the same medical conceptions of illness and symptoms as those undergirding official labels.” The same type of thinking may generate very different results depending on what the diagnosis is meant to do.

We see potentially disconfirming evidence for the ‘social construction’ of mental illness as an object. Good and colleagues (1985:216-217) found that a psychiatrist and two healers of different traditions defined “[t]he same historical issues and psychosexual problems … as central aspects of [the patient’s] present illness.” They continue to state that their interpretations differed, which led to different treatment recommendations (217-218). There remains, however, an unbending base upon which these are constructed (cf. Lester 2013:73-74 on “undermining deconstructions”). Earlier in the same study, they (194) propose multiple layers to interpretation, including “(1) the interpretation by patient and clinician of the discourse of the other in terms of their own conceptual models; (2) the interpretation by patient and clinician of a given theoretical or cultural model in terms of their own life histories and personal meaning systems” and a third not salient here. Light’s (1980:173-4) description of a case conference shows that different candidate diagnoses may be proposed among more uniform groups. I take their agreement on a unitary diagnosis as further indication of something underlying the label.

Labelling theory and indeed many social scientific studies of psychiatry suggest that
diagnoses decontextualize disorder (e.g. Boyle 2011; Pilgrim 2001; Whooley 2014).

Decontextualisation is defined by one sociologist as:

“[T]he tendency of the DSM, and psychiatric nosology generally, to fail to acknowledge the fundamental way in which mental distress—its distribution, manifestation, and meaning—are determined by and situated in social structures and cultural meaning-systems.” (Whooley 2014:93)

Whooley continues, however, to begrudgingly admit that “some of these problems are addressed in clinical practice” (2014:94). Neither psychiatric research nor assessment tools suggest an impoverished or asocial understanding of mental illness. If we look specifically at the premiere structured interview for PD, we find quite the opposite.

Careful examination of a descriptive diagnostic interview for PDs, the SCID-II6 (First et al. 1997), lays bare a labelling theorist’s nightmare. For instance, avoidant and narcissistic PDs are differentiated on an interpersonal criterion, whether or not they anticipate the criticism to which both react strongly (10). Additionally, there are repeated cultural caveats (e.g. arranged marriages don’t necessarily reflect dependent PD, 11) and an early reminder to score only “pathological, persistent, and pervasive” characteristics as present or true (7). Even the seemingly ironclad “empathy” criterion for NPD is contextualised (25): “They may have the capacity to demonstrate empathy (e.g., a successful therapist with [NPD]) but only if it serves their own purposes.” The centrality of social valuation to narcissists is also implied in the commentary on the envy question (ibid). In short, even descriptive psychiatrists needn’t be cartoon villains ticking off a checklist or malfeasant

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6 Structured Clinical Interview for DSM-IV Axis II Personality Disorders.
medicalising monsters. Psychiatry is shaped by national, local, and individual contexts, and therefore aware of this contouring. We can move then from the situational patterning of the process and its contents to examine why it is best modelled dynamically.

(1.2) More than a name or a moment, it’s alive!

A range of researchers have unearthed evidence of or espoused theories of diagnosis as process (e.g. Ainsworth-Vaughn 1998:Ch. 7, especially 170-171; Blaxter 1978). In emergency room psychiatric consults, diagnosis is described as a social and cultural process, proceeding from a folk to a medical to a psychiatric phase (Gaines 1979:384-390). Mirowsky and Ross (1989) operate at still further remove from clinicians. Their critique acknowledges diagnosis’ processual nature, but treats all four steps as problematic (12):

“The first is assessing a) the level of symptoms, b) the extent of impaired functioning, and c) the duration of problems. Note that ‘level,’ ‘extent,’ and ‘duration’ all refer to assessments of degree or amount. The second step is splitting each assessed amount at some cutoff, so that differences in degree are collapsed into two categories: amounts that meet the criterion (‘met’) and amounts that do not (‘unmet’). The third step is toting up the criteria, a step which further collapses all possible combinations of met and unmet on the three dimensions-a, b, and c-into a single overarching split. The fourth step is excluding cases that also meet other criteria which are considered preeminent, such as excluding grief from the category of major depression.”

Later, they (17) reduce this to a still simpler formula: “Diagnosis is a two-part process of gathering information and then ignoring most of it.” If we observed everything, however, we would be incapable of action: all humans sift information. The purpose of seeking expert help is that they are able to use technical knowledge to determine what is meaningful and needs to be acted upon.
Many of Mirowsky and Ross’ (1989) points on to the dimensionality of psychiatric illness would be well received by practitioners treating PDs. Interestingly, they come to the same conclusions that the NIMH recently has: that diagnosis (as presently constituted) isn’t particularly helpful in uncovering aetiology. Diagnosis as a *lingua franca* between clinicians of different orientations (Bowker & Star 1999:47; cf. Greenberg 2013:67) is ignored. Mirowsky and Ross (1989) instead argue psychiatry is tautological and standardised diagnosis is an effort on the part of psychiatrists for “enclosure of a scientific and professional domain” (22-23). Their editorial conflates diagnosis and classification. Psychiatric epidemiology and official classificatory systems have come under attack from several sources, including psychiatrists themselves (e.g. Patel 2014). While both acknowledge what Patel calls the “credibility gap,” the key difference is that the sociologists believe diagnosis to be “mythical.”

There exist, however, a few spots of sunlight in which a sociologist might find rich reports on how the process proceeds. We find them in institutional ethnographies (Godderis 2011), a study of diagnostic technologies (Schubert 2011), and an ethnography of interaction (Rittenberg & Simons 1985). I work through them in this order, progressively narrowing my focus.

Godderis’ (2011) informants “described diagnosis as a highly productive process during which they worked to transform in-depth knowledge about an individual’s lived actualities into a generalized representation of those actualities” (241). She
describes this work as situated within “circuits of accountability” (145-147). Crucial to my discussion, diagnosis is here an active and theory-laden process, involving parties other than professional and patient. She also stresses the translational role of diagnosis (cf. McPherson & Armstrong 2006; Lester 2009:287-288), and how reports may be written to protect patient privacy (148-149).

Godderis (2011:141) provides an extremely helpful schematic of the diagnostic process:

*Mapping the Diagnostic Process in Psychiatry* 141

![Psychiatric Diagnostic Work Process](image)

*Fig. 1. Psychiatric Diagnostic Work Process.*

While this figure is useful in conceptualising psychiatric diagnosis, its downside is its linearity. Antaki, Barnes, and Leudar (2005:630) and Johnson (1985:274) indicate that this process is recursive, as does Schubert’s (2011) ethnography of anaesthetists in surgery.
I follow Schubert (2011) in asserting that “performing a medical diagnosis and initiating subsequent treatment is not considered to be a steady flow of well-known sequences, but rather as the continuous work of turning indeterminate situations into manageable problems” (852). He draws on Dewey and reminds us “tools are neither neutral, nor are they autonomous” (853). In other words: tools aren’t actors in this understanding. Monitors or diagnostic interviews give access to the patient, but simultaneously also create a distance between practitioner and patient. Diagnosis represents “an ongoing activity of ‘making sure’ throughout the course of an illness trajectory” (857).

Rittenberg and Simons (1985) microscopically probe the first psychiatric evaluation as a social encounter. When eliciting relevant stories, there is a three-part sequence: a “framing statement” such as “a moment ago you said”, followed by a “repetition or paraphrase of the patient’s words”, and a final request for elaboration (178). The psychiatrist thereby “legitimizes his interest in the event” and also evades any potential uncertainty about what knowledge is sought (ibid). The patient’s stories are given “an additional special kind of analysis in order to extract from it those points and possibilities which can then use to suggest alternative constructions” (179). A broadly narrative approach is taken because this sets the patient more at ease (and facilitates collaboration), and allows for digressions and variations in level of detail (180). These latter two serve as interactional resources available to the interviewer to help direct the talk’s flow toward clinically-relevant materials. Another resource is temporality: first, “when a patient is speaking too long and
unilluminatingly on an event … [the interviewer] can proceed to the next happening in the sequence” (182). Further, the psychiatrist can “[slow] down time” or request the patient to fill gaps (183) in order to focus more closely on sequencing. “Intermittently … the interviewer also formulates his construction of parts of the story … for the patient to confirm or correct” (187).

Some social scientists have examined what happens after deliberation: diagnostic disclosure, or a lack thereof. Sulzer’s study (2015) echoes Lester (2009) in finding that BPD is an exclusionary diagnosis, but here practitioners – not insurers - were engaging in “overt and active pruning” (86). She frames her study as one of de facto demedicalization, drawing on the medicalisation literature to demonstrate that “medical labels and treatments are determined across a variety of sites by a variety of people who are unlikely to be entirely in agreement because medicalization is a contested process rather than an absolute category” (84). Her thesis (2012: Ch. 4) indicates that clinicians’ “practices fall into three categories which exist on a spectrum of acknowledging the disorder: relying on Axis I definitions, using euphemisms, and discussing the disorder directly while addressing stigma” (64, cf. Sulzer et al 2015).

Ecks (2014:165) explains that “Calcutta psychiatrists said that diagnoses and medication should be explained to patients as much as possible.” He earlier cites an informant who states that the word depression is avoided in favour of vernacular terms (e.g. “mental tension,” [ibid]). The process my informants called translation is suggested in his respondent’s statement (ibid), explaining “That’s the language they
understand and that is how we treat them.” Ecks frames this behaviour in his introduction as “deception” (10-11). He states (11) that, “In the absence of effective regulation of the way doctors must explain diagnoses and treatments to patients, they tend to prefer obfuscation to transparency.” Amongst my respondents, I found similar work being done – though I’ll argue it’s more conversion than covering up.

(I.3) Theory: “[They practice] it whether [they know] it or [want] to or not”

Theory is so commonplace we might take it for granted, no longer even noticing that we’re wearing lenses. Parsons (1952) captured this irony in a series of erudite metaphors:

“Psychotherapy to the militantly anti-psychiatric organic physician is like theory to the militantly anti-theoretical empirical scientist. In both cases [they practice] it whether [they know] it or [want] to or not. [They] may indeed do it very effectively just as one can use a language well without even knowing it has a grammatical structure.” (462)

We see here Fleck’s (1979) thought style: “a definite constraint on thought, and even more; it is the entirety of intellectual preparedness or readiness for one particular way of seeing and acting and no other” (64). “The ability directly to perceive meaning, form, and self-contained unity is acquired only after much experience, perhaps with preliminary training” (ibid:92) Both Fleck and Kuhn7 (1996:47) suggest we adopt a thought style through doing, though Kuhn allows training a greater role. If we accept that thought styles are an unavoidable part of perception (cf. Gellner 1993:90-94), and that training and experience induct a novice into a given thought community,

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7 Some hold that Kuhn plagiarises Fleck (White 2015), because of this and Fleck’s greater clarity, I favour Fleck’s phrasing.
studies of medical and psychoanalytic training gain special relevance. Initiates haven’t yet had time to internalise these modes of thinking and seeing, and may be punished for seeing and so behaving the wrong way (e.g. Luhrmann 2000:39-40 on medication missteps). Briefly, thought styles become more explicit in an educational setting.

Luhrmann (2000) is here indicative: “By their second year, residents begin to talk about the ‘feel’ of the disorders” (40). She describes a shift from memorisation to thinking of a prototype, or “a cluster of characteristics that constitutes a ‘good example’ of a class” (41). Light (1980) goes so far as to baldly state “that learning to diagnose socialises one into the prevailing ideology” (160). Biomedical competence, Atkinson (1995:79-80) has argued, is the ability “to discriminate and to describe phenomena using complex series of categories and descriptors that are not available to the layperson or the novice.” It is not just psychiatry, these quotes suggest, where learning how to “see, hear, feel, and smell” (Atkinson 1997:170, cf. 164-173) is the logical basis of treatment not only scientifically, but also socially (cf. Fox 1957:214). Medicine – and also psychotherapy – “is the art of adjusting scientific abstractions to the individual case” (Hunter 1991:xvii).

Supervision, through its intense focus on a resident’s thoughts and responses (Luhrmann 2000:61), inculcates a certain way of seeing and relating to patients (ibid:60-4; cf. Light 1980:188-194 on case conferences). Skills imparted here make therapy more predictable by passing on certain rules of thumb or theoretical wisdom to trainees (60-75, 102-118). Luhrmann implies that young psychiatrists use
“emotion-motivation-behaviour bundles” as a basic unit around which they organise the details of psychotherapy sessions (71). Even their gossip serves as therapeutic training, whereby such bundles are observed and can be explained with contrast to theory or to experience (78-81). Davies’ “pre-training therapy” helps to socialise the novice psychodynamic psychotherapist by seeing how the process works on themselves first (2009: 56-60). Requiring this also “ensure[s] that all trainees who enter [training] programs are disposed favourably to the psychodynamic paradigm or process” (ibid:60-61).

A biopsychiatric or pharmacological approach to mental illness naturally also entails a thought style. Lakoff (2005:111-112) and Luhrmann (2000:175-177) both report a psychiatrist’s conversion after seeing medications work, thus shifting them away from psychoanalytic thought. *Pharmaceutical Reason* (Lakoff 2005) is essentially the story of the contest between the perspective that “targeted drug treatment will restore the subject to a normal condition of cognition, affect, or volition” (7) and a particular Argentine brand of psychoanalytic thought. Although his informants (and arguably also Lakoff) treat the neuroscientific/pharmacological and psychoanalytic/hermeneutic as two distinct and incommensurable paradigms (e.g. 2005:62-66), I argue there is slippage. The empirical chapters will pursue this further, but I argue that there are (at least) three ways in which theoretical traditions can relate: amalgamation, segregation, or translation.

Segregation is based on the Kuhnian notion that “differences between successive paradigms are both necessary and irreconcilable” (1996:103). There is strict
separation, as the name implies. Fleck (1979:36) states that “direct communication between adherents of different thought styles is impossible.” Here enter the possibilities of translation (cf. Kuhn 202-204) and amalgamation.

I understand translation as analogous to Cordner’s (2015) strategic science translation, “the process by which stakeholders interpret and communicate scientific evidence to an intended audience for the purposes of advancing certain goals and interests” (916). Diagnoses can also be translated, usually into the language of the DSM or the ICD: Categories thus become liquid (Lakoff 2005:21-22) or “transferrable” (ibid:13, 35; see Bowker & Star 1999:47 on the DSM as a *lingua franca*\(^8\)) across different contexts (national borders, insurance-clinic, clinic-lab, etc.).

“[T]ranslation is a merging between two networks” (Collins 2000:1033n5).

There is a still more fundamental translation, from the patient’s narrative “into an objective, scientific – or… a reliably intersubjective and [psychotherapeutically] recognisable – account” (Hunter 1991:52). Though she repeatedly uses the metaphor of translation (e.g. 54, 125-126, 146), Hunter ultimately argues that professional and patient narratives are “incommensurable” (124). This communication gap exists in part because of patients’ inability to judge physicians’ technical skill (Parsons 1952:441-442).

Amalgamation is the combination of elements of different thought styles, whether within a school or an individual clinician. Fleck (1979:110) predicts that such

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\(^8\) I refer to the DSM as a *lingua franca* throughout, but will not repeatedly credit Bowker & Star as if they coined the term.
blending “sentences the person involved either to lack of productivity or to the creation of a special style on the borderline of the field.” French eclectics use DSM for research and statistics, but conceive of their patients in psychoanalytic terms (Lloyd 2006:237; cf. Pickersgill 2010a on American researchers combining psychosocial and biological approaches to antisociality). Smith (2014:82-83) reports similar practice among US psychiatrists with psychoanalytic training. These psychiatrists may see a biological element to the aetiology of mental illness (Smith 2014:83-84), and use medication as a “precursor to talk therapy” (86-87; cf. Lakoff 2005:83-86 on similar practices in Argentina). A debate regarding whether response to an anti-depressant could inform clinicians if the patient had obsessive-compulsive disorder or psychoanalytic psychosis (Lakoff 2005:163-167) represents a case containing both translation and amalgamation.

Amalgamation, as I’ll suggest in the case of schema therapy, serves to innovate and allow an approach to stand out in a crowded marketplace. The second apparent function of this blending could be seen cynically as threatened thought styles seeking to insure their survival (e.g. neuropsychoanalysis and psychoanalytic readings of neuroscientific evidence, Ronningstam & Baskin-Sommers 2013). A more optimistic reading is that this represents a form of consilience. Clearly it could be both. What, however, does socialization show students about speaking? How are these pliable but prickly thought styles related to patient-practitioner interaction?

Light (1980:173) argues, “The heart of psychiatric socialization is not … to change behaviour, but to recast present behaviour in a certain interpretative framework or
belief system.” The sentences directly preceding these suggest, “Even anger and aggression against the patient have their [professional] uses. What matters is that one recognise what one is doing” (172-173). Interactional technologies are an array of interventions. To distinguish them from intellectual technologies may be artificial, but it offers an abundant analytical harvest. Rose (1998:54, cf. p.120) points up how knotty untangling them can be: “Language – here psychological theories, concepts, entities, explanations – makes up a kind of intellectual machinery which can render the world amenable to being thought but only under certain descriptions.” Empirical examples from experts and initiates alike suggest that the two technologies, at barest minimum, extensively overlap.

Gaines (1979) describes four psychiatric residents as having “at least four different definitional and diagnostic orientations (but at base, only three aetiological views)” (406). These intellectual technologies generated, unsurprisingly, varied ways of managing the patient/physician relationship (404-405; cf. 410 and 414n11 on the notion of specific “treatment styles”), and rather dissimilar diagnostic patterns (400-404, esp. p.402, Table 3). A conceptual model serves as a template of sorts for psychiatric practice (Strauss et al. 1964), as Zelizer (2012) and Schegloff (1963) might predict. Prior’s (1991) comparison of Breuer and Freud, fin de siècle Irish asylums, and a psychiatric rehabilitation ward provide a diachronic demonstration of this link. But what about the content of this communication? Our procession will now peruse just this privileged parole of psychotherapy.
(II.) Patient or Client? Are We Medical? Peripheries of Psychotherapeutic Parole

Speech styles of the theoretical traditions expose us to the question of how the patient-practitioner boundary is maintained in the moment, and across time.

Diachronic management bears one of the stickiest questions surrounding psychiatry: What makes a therapy medical? Put plainly, when does a method follow the medical model? I begin, here as in the chapters to come, with the second question.

Thereafter I move onto the issue of client communication, jumping from its ritual elements to the more practical matters of workaday discourse. Overall, I argue that no one I’ve encountered has a good definition for the medical model, let alone a means of determining the devotion of any one approach. The second intimation is that, looked at turn-by-turn, ostensibly opposed psychotherapies show shocking amounts of similarity. Now, I shall attempt a demystification of the medical model.

(II.1) What’s in a medical model?

It’s often assumed that an understanding of the medical model (MM) is simply in the aether, equally accessible to everyone. Smith (2014:76) loosely defines medicalisation, but doesn’t elaborate on what precisely the MM is. Meanwhile, physicians (Emanuel & Emanuel 1992) outline four models of the doctor-patient relationship: paternal, informative, interpretive, and deliberative (see table, pg. 2222). Social scientists seem to presuppose that the MM and disease model of illness are identical (cf. Mehan 1990:171, which adds that “cause and cure of mental illness… is to be found in the biological realm”), or else that is the disease model ensconced in a paternal model of physician-patient interaction. Rose’s answer
(2007:700; cf. Pickersgill 2010b:388) that “there is no single [MM]” addresses the question in letter, but not spirit.

Goffman (1961a) casts medicine (and also psychotherapy) as an expert personal-servicing profession (324-326) sharing a rational three-part process with other tinkering trades: “diagnosis, prescription, treatment” (331). Key to this is the notion of “the body as a serviceable possession – a physicochemical machine” (340). He argues that this model is readily applied by psychiatric professionals: “A uniform professional courtesy shown to patients is matched with a uniform applicability of psychiatric doctrine” (351). Goffman lends life to Parsons’ Pinocchio: universality, affective-neutrality, and collective-orientation of the doctor’s role (1952:434-436) are shown in action in the mental hospital.

Perhaps we can find greater clarity if we turn to a conversation analyst (Bergmann) and a psychotherapist (Streeck). Streeck suggests that there are two models of psychotherapy: one medical, the other interactional (2008:174-176). What distinguishes a MM of psychotherapy, he argues, is that “psychotherapeutic competency would prove itself by recognising and eliminating inner psychic causes underlying the mental disorder” (174). The interactional model sees both parties’ actions, “their interaction and the relationship they create as constitutive of psychotherapy itself” (175). Bergmann’s (1992) focus narrows to “psychiatric discretion” (157) as used during intake interviews. He argues that these utterances are both medical and moral, but offers no solid evidence for what he calls “the moral version of the discreetly exploring utterance” (156).
Messinger (2006) concludes “psychiatrists have a lingering responsibility for managing the social ills reminiscent of the age of the asylum—that is, poverty and social marginalization translated into symptoms of mental illness” (384). This represents a “paradox” for him, given psychiatry’s “[turn] to strict interpretations of biomedical models of illness” (ibid). One possible exception here is Davies et al. (2006:1100-1101), who equate it with “medical primacy” and the pharmacological treatment of mental disorders. Messinger (2006) and Davies and colleagues (2006) respectively remind us that a profession’s history impacts its present relations, and that understandings (e.g. a criminogenic perspective on mental illness, 1101-1103) can cross-cut professional lines. The biomedical model in psychiatry is elsewhere described as the idea that “biomedical disorders in the brain are manifest in the symptom clusters of patients” (Whooley 2010:464). Ultimately, this contains three elements: (1) there are discrete mental illnesses, (2) these diseases reflect some dysfunction in the brain, and (3) if medics can identify them, they can treat them.

Hunter (1991:20-21) follows doctors in suggesting that the biomedical model is a useful “myth, … serving as an ideal of medical-scientific rigour which physicians hope to approximate but don’t put into practice because of its potential harm to patients” (21). In the same passage, she explains that the biopsychosocial model has flopped because medicine is already multilevel. Sociological studies suggest that indetermination and technicality blend (Atkinson 1997:181-188). One paediatrician simplified this to a continuum on which medical specialities fall between “the caring sort of medicine and the organizational sort of medicine at the other extreme”
(Strong 1979b:204). Thus far, I’ve suggested that the MM is insufficiently defined, giving us only gross detail about the way interaction is structured. What I demonstrate now is that, as Goffman indicates, ritual elements adhere in any conversation. Ceremonial and moral concerns help to further order the interaction, helping it to achieve its institutional aims (Strong 1979b). A conceptual model aids psychotherapists by providing blueprints of correct and incorrect means of relating to the patient. We look now upon how psychotherapeutic speech is ritual, ethical, and situational, and how theory helps here.

(II.2) Ritual and ethical elements of interactional technologies

Schegloff (1963:64) refers to the “interchangeability (or reversibility)” of psychiatric theory, meaning that the model can be “relevantly” applied to practitioner as well as patient behaviour. While his concern was on psychodynamic practitioners, we can see that this extends to more cognitive approaches as well (e.g. limited disclosure in schema therapy). He further argues that “the topic of the relationship (and of what goes on within it) is the relationship itself, the persons implicated in it, and the nature of their implication in it” (65). The capacity for metatalk and more explicit remedial work is inherent in psychotherapy, but I’ll argue that this isn’t the focus – or not universally so.

“[T]heory imparts to the behaviours of patient and therapist their psychiatric sense, and the proper syntax by which behaviours may be related to one another as parts of an understood orderly arrangement” (Schegloff 1963:70-1). Models act as both ways of seeing (70-72) and dictating how the therapist ought to respond (72-74). Rules
regarding moral propriety and even logical coherence are left at the door (67-71; Luhrmann 2000:188-191). Theory suggests not only the proper actions, but also how material is interrelated (74). A substantial of Schegloff’s paper (1963:79-91) is devoted to the question of how people learn to be patients. Part of this is mastering a different way of seeing and relating to the world, which is transmitted during the sessions. While other therapies and even psychodynamic psychotherapies don’t include “the elimination of accounting features” (86-90), there is a minimisation of these same features. Therapists don’t react to our stories the way our ordinary interlocutors do, nor would we want them to. Psychotherapy patients must be inducted into that role, and have that role ritually reaffirmed and reproduced. Each school of therapy must therefore have a body of knowledge related to the therapeutic encounter and how it is to be managed.

While ordinary rules of face and politesse are suspended, a new set replaces them. There emerges a local etiquette and local rules, which must be mastered by both interactants. Peräkylä and Vehviläinen (2003:729-730) define “stocks of interactional knowledge” (SIKs) as “normative models and theories or quasi-theories about interaction… found in professional texts, in training manuals and in written and spoken instructions delivered in the professional context of professional training or supervision.” While SIKs and interactional technologies aren’t precisely the same, I’ll use the terms equivalently. Knowledge (of this type, anyhow) is not idle, but represents knowledge-in-interaction as much as it is knowledge of interaction.

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9 Psychodynamic psychotherapies use psychoanalytic principles and theory, but are conducted face-to-face rather than with the patient on the couch and the therapist seated behind.
It might be objected that SIKs deploy universally available conversational resources. Like Turner (1972:396), I “suppose that any psychiatric theory provides therapists with a warrant for hearing patients’ utterances as coming under a rule suspending routine conversational constraints. From the time the session ‘begins,’ patients’ utterances are to be treated as ‘data’…” But as I’ve suggested, this necessitates the formation of a new set of rules, which is built by theory out of the everyday materials at hand: The same wood might build a house or a boat, but they aren’t made the same way.

Ritual forms of talk differ (see Ferrara 1994:39-45 on psychotherapy). Whereas certain issues are politely disattended in everyday talk (see Goffman 1961b:19-26 on rules of irrelevance, especially pp. 23, 25-26; Strong 1979b:39), “… in principle, everything produced within the [therapeutic] relationship is available as a resource” (Schegloff 1963:67). In psychotherapy, I argue that both parties are “obliged to show constant orientation to the gathering as a whole and constant devotion to the spirit of the occasion” (Goffman 1963:199). Davies (2009) doesn’t openly say that psychotherapy is a ritual (81-83), but indicates that all the relevant features (temporal [65-67], spatial [67-73], and relational [73-81] boundaries) are present. The ritual model also fits with an understanding of human cognitive-processing: “any particular description or interpretation of some activity, event or object is necessarily selective”, rendering the results “partial knowledge” (Davies 1981:35). Ainsworth-Vaughn (1998) reminds us that “all studies, even qualitative ones, do ignore some context” (16). To critique a scientist or psychotherapist for seeing things a certain,
circumscribed way is therefore to harangue their humanity.

I call ritual resources of a higher order ceremonial superstructures (my term). Parsons points out therapists’ use of a folk model such as father or best friend (1952:462n17) which braces the interaction. Strong (1979b) introduces the concept of “role format” (10-13), which he uses to refer to “the entire ceremonial order” of both the occasion’s frame and its many possible situated roles. It is a resource, a blueprint, and role formats can be altered and combined to fit the moment’s needs “so long… as the participants agree” (1979b:12-13). Strong’s notion of the role format as a flexible (though not indefinitely so, see 1979b:13, 17, 106), practical means of channelling the interaction has resonances with psychotherapy. In some sense, we could say that each theoretical school develops its own role format or ceremonial order to:

“[diminish] uncertainty, [cut] out initial skirmishing, and [enable] a rapid concentration on the task at hand. … [S]econd, as such a form enters general use, it acquires a moral as well as a political and technical force and becomes, not merely one way of solving things, but the way these things ought to be solved” (Strong 1979b:193).

Here, however, the similarities ceases. Strong (1979b:39) implies all rules in his central ceremonial order “are established by the same fundamental procedure, that of avoidance.” Mental illness seems to require more visible scaffolding, more outright negotiation of the definition of the situation.

Treatment contracts are the most blatant example. A GP treating someone who, by their telling, “is not really ill, but has a [PD] and sometimes harms herself to seek attention” explained that “informal contracts… concerned with limiting such
behaviour” were used (Shaw 2004:1041). Sulzer (2012:50) points to explicit “contracts which detail appropriate care practices that the patients deem to be overly invasive or infantilizing, and aren’t administered to other groups of patients.”

Role induction is perhaps the easiest superstructure to dismantle, and is even used in controversial treatments such as electroconvulsive therapy (ECT, Stevens & Harper 2007:1481). Orne and Wender (1968) explain that a “preliminary socialisation interview” can serve four purposes in psychotherapy: “establishing rapport,” explaining how the process operates, clarifying both participants’ roles, and even helping to “anticipat[e] the patient’s resistances” (1207-1208). If we look deeper, we will find similarities across SIKs not just at the level of ceremonial superstructures, but also as deployed in everyday psychotherapeutic exchanges. I turn now to this reanalysis of selected conversation analytic (CA) literature on psychotherapy.

(II.3) Subterranean similarities of psychotherapeutic speech

To recap, we’ve seen that theory inescapably seeps into diagnosis and the therapeutic interaction, and that both of these contain ritual elements. There exists a competition for clientele, operating in the background, but which nevertheless impacts the situation. We turn now to the particular solutions theoretical schools have established to these practical problems of establishing both solidarity and the local norms. These are, to repeat, what I refer to as interactional technologies or SIKs.

10 I thank my pre-IOP psychotherapist for introducing me to Orne.
11 CA refers both to the method and its practitioners.
While CA studies of psychotherapy are relatively few, I couldn’t read all the papers and books in this area. I therefore make no claims to comprehensiveness, but I suggest that we can generalise more than ethnomethodologists themselves have done. Careful attention to the details of this research indicates a high degree of similarity across therapeutic schools and also their debts to earlier forms of psychotherapy. While I’ll attempt to keep the text as jargon-light as possible, some is inescapable. We therefore take a definitional detour.

Formulation is used in two different ways in this literature. The first refers to Davis’ (1986) notion of therapeutic formulation as a particular process in psychotherapeutic talk (on which more later). For reasons of clarity, her concept is sometimes called reformulation (Antaki, Barnes, & Leudar 2005:629), a practice I adopt here. The other definition is more general:

“[O]ne speaker formulates what has just been said (either by summarizing the gist of it, or by drawing out its relevant upshot), then the other speaker is expected to take the opportunity to acknowledge that formulation, and to ratify it.” (ibid:627)

Formulation will be used in Heritage and Watson’s (1979) sense as summarised by Antaki et al. above. Three main similarities will be stencilled out in the following order: (1) the conversational cycles by which therapists come to clinically relevant material, (2) their means of dealing with emotion, and (3) how empathy and sympathy emerge.

Hutchby’s (2005) point that “active listening in naturally occurring child counselling dialogues is… less a matter of listening per se, and more a matter of listening for a way to formulate what is said as therapeutically relevant” (308-309) would, however,
appear to suggest the opposite. He upgrades a manual’s directive not to ask “too many questions” into an absolute ban on questions (309, 327n5) and refers to the therapist as “neutral conduit” (e.g. 310, 319; n.b. this is his term), rendering his analysis somewhat suspect. Examination of the question-answer-formulation (QAF) sequence as “unfolding therapeutic matters” (2005:317-325) points out a “stepwise technique that culminates in the formulation of therapeutically relevant matters” (320). To say such a mechanism is universal to psychotherapy could be taken as inconsequential, as such descriptions are rather abstract. The repeated emergence of both a particular form and tone suggest that this is not an unnecessary observation.

If we take classical psychoanalysis as an origin point, there are clear parallels between child counselling and psychoanalysis’ “interpretative trajectory” (Venviläinen 2003, 2008). Venviläinen (2003:579-580) describes three moves which precede interpretations: extensions, formulations, and confrontations. She argues that these interventions “invok[e] a puzzle” (580), which the interpretation then solves. Extensions and formulations seem to be particular types of clarification, or “the therapist’s invitation to explore and explain any information that is unclear, vague, puzzling, or contradictory” (Yeomans, Clarkin, & Kernberg 2015:155).

We see an analogous series in cognitive-constructivist therapy (Voutilainen et al. 2010a). Misalignment, or “the way in which participants to an interaction in a given moment steer their interaction in diverging directions” (ibid:300), may actually be used to advance the therapy. Voutilainen and colleagues (2010a) indicate a two-stage
process, whereby the first phase is concerned with “distancing from the emotion” (301-306). There are three ways the therapist may do so: (1) “focusing away from emotions” (302-303), (2) “detailing the emotional experience in a detached way” (303-304), or finally, (3) “calling into question the patient’s emotional experience” (304-306). The last sounds crueller than it is: there, the practitioner uses Socratic questioning to make the patient’s “dysfunctional cognitions” and “maladaptive assumptions” (terms from Beck et al. 1979) open to investigation. In the second phase, the focus shifts to the here-and-now. Goffman might call this rupture or relationship repair. This intervention is, so to speak, double-barrelled: through this remedial work (Goffman 1972:Ch. 4, especially 108-119), the therapist also “takes distance to the affect that she is describing and so directs the interaction to a frame of reflection upon feelings rather than expression of them” (Voutilainen et al. 2010a:309). In sealing the rupture, the practitioner also presents a model of emotion regulation and self-distancing.

Antaki, Barnes, and Leudar (2005) draw on recordings of CBT, an approach often invoked as the opposite of psychoanalysis. We would therefore expect a different interactional pattern. The stage they describe as pre-diagnostic formulation, “getting the history, circumstances and symptoms” (630-2) matches quite closely with clarification and the question in Hutchby’s (2005) QAF sequence. “Therapy-leaning diagnostic formulations” (Antaki et al. 2005:632-634) are identical with those Hutchby (2005) sees in child counselling. Depending on the content, we can parallel this with psychodynamic confrontation (or “invitation[s] to reflect” on material the practitioner deems important, Yeomans et al. 2015:156) which can be both
“confrontative” and “collaboration-oriented” (Venviläinen 2008:126-128, quote on 127). Skill is needed in the phrasing and timing of both psychodynamic confrontation (Davies 2009:196-200) and therapy-leaning diagnostic formulations. Another parallel is with Rae’s (2008:70-74) lexical substitutions, that “propose clients should express their feelings in a more explicit, unvarnished, way” (74). Indeed, such “respecification” can help to establish “therapy-relevant identities” and to form the therapeutic alliance (Rae 2008:79). Sometimes it is, however, merely a means for generating a problem list which will guide the therapy (Antaki et al. 2005:634).

Bercelli and colleagues (2008) propose that this QAF series or interpretative trajectory can form chains of elaboration (44-45; cf. Ferrara 1994:137-138). They build on a corpus of Italian cognitive and relational-systemic therapy, but I maintain that their recursive (therapist question-client answer-therapist statement-client-response) sequence is generalizable to other therapies. Metaphor (Ferrara 1994:Ch. 6) and so by extension idiom (Antaki 2006) can both help to build these elaboration-chains (my term). Both authors indicate that “metaphor constitutes a nonthreatening way to talk obliquely about problems” (Ferrara 1994:129; cf. Antaki 2006:536-538). It is noteworthy that Bercelli et al.’s example of extended agreement (2008:56-60) is also an example of an extended metaphor (Ferrara 1994:138-145). At least one of Peräkylä’s examples of psychoanalytic intersubjectivity (2008:114-118) is an extended metaphor (cf. Venviläinen 2003:581-584). “[M]etaphor distils and compresses thoughts and feelings” (Ferrara 1994:129), or in Antaki’s terms, idiom

12 “[C]onfrontation as a therapeutic technique should always be carried out with courtesy and tact, and above all, with genuine curiosity” (Yeomans et al. 2015:157).
serves to “[represent] the client’s position” (2006:530-536). What we see here are various elaborations of reformulation. Davis (1986) defines it as a three-stage process consisting of “definition of the problem, documentation of the problem, and organization of the client's consent” (54, her emphasis). I argue that Bercelli et al.’s elaboration-chains form a generic interactional strategy, which is then modified in line with a therapeutic school’s intellectual technology. We see then the genesis of specific interactional technologies which appear different but hide subterranean similarities.

Voutilainen et al. (2010c) report that “responses which have the patient’s experience as their referent are basically of two kinds”: recognition and interpretation (89).

“[I]nterpretation, in a generic psychotherapeutic sense, … point[s] at something that is implicit in the patient’s experience” (89) and “appears to be a purely psychotherapeutic response” (103), whereas recognition conveys comprehension of the character and reality of the patient's emotional experience (89). Ultimately, Voutilainen and her collaborators conclude that interpretation is a “cognition/consciousness centred” and recognition an “emotion-centred therapeutic [action]” (2010c:104). More crucially, “in the therapist’s response to the patient’s expression of an emotional experience, there is no interpretation without recognition” (104).

Rae (2008) contrasts lexical substitution as used by a practitioner of “integrative psychotherapy” (63) and disagreements and formulations drawing upon the patient’s own words. The former recognise that a patient’s feelings are more intense than they
let on (70-4), as when a patient says “I can do jolly,” and the therapist replies “Pretend jolly” (66). I feel the latter are also lexical substitutions but they propose a new topic or direction rather than encouraging the patient to be more earnest. In proffering this new path, the clinician “challenges beliefs ascribed by (or attributable to) the patient” (74-78, quote on 77). What Rae refers to as lexical substitutions can be classed as recognitions, whereas disagreements and formulations are interpretations (in Voutilainen and colleagues’ [2010c] sense).

Bercelli et al. (2008) coin the term reinterpretations, “through [which] therapists forward their own perspectives, ostensibly shifting the point of prior clients’ versions of their own events or possibly forwarding some divergence from them” (48). The very language of the concept suggests its relation to interpretation, though emphasising that they “display some independency from clients’ talk” (ibid). Psychoanalytic interpretation may display many of the same markers, but differs in that “inferred, hypothesised unconscious material believed to be exerting an impact on the patient’s motivation and functioning” (Yeomans et al. 2015:157) is also deployed.

Other times even recognition may be blunted. In history-taking sessions, otherwise clinically relevant material (“graphic and distressing experiences”) might be glossed over or minimised (Antaki et al. 2005:635-638). Such moves serve to either get the pre-patient to elaborate (Bergmann 1992:144-146) or to keep the session from bogging down in a single detail (Antaki 2006:538-539). Discreet utterances,  

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13 Unless otherwise noted, I mean recognition and interpretation in this sense.
however, may “misfire” (*ibid*:638-641) by giving the patient an ‘out’ through a legitimate topic which is not what the questioner intended to learn about.

Alternately, others claim such minimal recognition can be iatrogenic as pre-patients may hear “veiled morality” and react with outrage (Bergmann 1992:157). Bergmann (1992) goes on to describe this as “fatal” (and by implication a self-fulfilling prophecy), but then attempts to save face by placing the onus on the profession, not its practitioners (157).

I’d be negligent not to discuss empathy, as it “maintains a kind of ‘interactional and emotional infrastructure’ of psychotherapy” (Voutilainen et al. 2010c:813). Ruusuvori (2005) sought to analyse sympathy and empathy as constituted interactionally in Finnish GP and homeopathic consultations. She finds that “empathy in action” is a three stage process, consisting of (1) proposed affiliation and patient confirmation, (2) expression of solidarity whilst reaffirming the patient’s ownership of the narrative, and (3) “[t]hey treat the patient’s experience as relevant and possible by offering further details of the kind of situation described by the patient” (219). Potential outcomes of such events are often used to establish this common point of reference (*ibid*). Sympathy differs in that the clinician shifts the focus from the patient to themselves, leading to patient resistance in this instance. Young (1995:217) reports that therapists’ “pseudo-confessions” (e.g. having been a war resister during Vietnam) are similarly seen as “worthless” and “risible”.

While Wynn and Wynn (2006) also examine empathy as “an interactionally achieved phenomenon,” their study looks for how subtypes (sharing, cognitive, and affective
empathy) are produced. Ruusuvuori’s (2005) focus on the general mechanism makes her study more generalizable, despite Wynn and Wynn’s (2006) analysing videotaped sessions of brief eclectic psychotherapy. A recent study of how behavioural change works in CBT (Ekberg & LeCoteur 2014) fits nigh-perfectly with the model of empathy in action. Clinicians’ suggestions for behavioural change are more acceptable when the practitioner is seen as “re-shaping” the client’s suggestion (68-71). “In this way, it is the client who is able to have the ‘last word’ on whether to accept or reject the therapist’s participation in the sequence” (70). When “the client is not co-implicated in the suggestion making process”, the therapist’s proposed behavioural change tends to be rejected. Talk seen as placing the practitioner centre-stage flops, however well-intentioned (Ruusuvuori) or cautious (Ekberg & LeCoteur). Joint productions\(^{14}\), in Ferrara’s (1994:Ch. 7) phrasing, may be “not only a signal of empathy, but a means of creating empathy or the appearance of it” (147).

The relationship repair/reflection modelling moves taken by a cognitive-constructivist therapist (Voutilainen et al. 2010a:308-312) is successful because it follows Ruusuvuori’s recipe. Examining resistance to optimistic questions in narrative and solution focused psychotherapy, MacMartin (2008) found that clients founded their resistance on “the notion that clients, not therapists, are experts on their own experience” (96). There is a parallel here with premature interpretations in psychoanalysis, which “are ‘true’ interpretations communicated to the patient before they can make sense” (Rycroft 1995:86). In short, inadequate empathy or insufficient build-up seems to doom a psychotherapeutic performance, regardless of

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\(^{14}\) “Joint Productions are interlocked utterances that are the result of one speaker’s initiating a proposition and a second speaker’s completing or extending it in a syntactically and semantically consistent manner” (Ferrara 1994:146).
specific interactional technology.

But clinicians can bounce back from such bloopers. Some narrative and solution-focused therapists realise this, and thus incorporate “further details, drawn from the client’s misaligned prior turn” (MacMartin 2008:94). This affiliative outreach was attempted whether therapists “reissued” the same question (92-94), or attempted to find an optimistic spin on the client’s reply and substituted “a neutral question” (94). Different registers might be used in an attempt to break through, to connect. For instance, a child counsellor faced with constant repetitions of “don’t know” attempted to switch between playful and serious replies (Hutchby 2002:158-165; cf. Strong 1979b).

I close with one of the few comparative CA studies (Weiste & Peräkylä 2013), wherein roughly 23 hours of psychoanalysis and cognitive therapy are contrasted (301-302). Two types of formulation were found to be common to both, and had roughly equivalent prevalence. Highlighting formulations involve “the therapist select[ing] a part of the client’s prior turn, [and] recycling some of the key elements” which “contain therapeutically relevant informant” (303; cf. Ferrara 1994:118-125 on “mirroring”). Given that their example of such information was “emotionally heightened descriptions of the client’s experiences” (303), I feel safe subsuming highlighting formulations under recognition. Rephrasing formulations entail “the therapist offer[ing their] reading of a key aspect of the client’s narration” (306). Weiste and Peräkylä themselves point out a similarity to Bercelli et al.’s reinterpretations (2008:48). I extend this and class rephrasing formulations as a type
Relocating formulations (Weiste & Peräkylä 2013:309-311) were unique to psychoanalysis, and described as “bear[ing] a close affinity to what classical psychoanalytic theory refers to as interpretation” (317). These interventions involved propositions “that the experiences described in the client’s narrative were connected to experiences at other times or places” (309). First, it is interesting that it bears a similarity to two types of client retelling: “different events-same point” (Ferrara 1994:55, 67-72) and “similar events-same theme” (55, 72-81). Forrester and Reason (2006) hold “that any particular moment in the psychoanalytic encounter can be understood as being defined by three co-existing and mutually determining temporalities” (47). These temporalities are “the ordinary and mundane temporality of everyday life”, that of “the participants’ distant or remote past”, and finally, “the here and now of the rather unique conversation which takes place between client and therapist” (47). What Forrester and Reason’s study adds is a thorough description of the temporal nature, but they miss “the transference of the patient’s internal reality into the external reality, which they do all the time but without awareness” (US-P-1, 22.05.2014). Weiste and Peräkylä (2013) capture this type of “relocation,” which we see also in Kleinian play-therapy (Leudar et al. 2008:158-168). They then introduce the method unique to cognitive therapy: exaggerating formulations (2013:312-315).

Such interventions “are constructed to challenge the client’s previous talk by casting it as something that is apparently implausible or even absurd” (ibid:312). We saw
something similar in an earlier study’s “integrative psychotherapy” (Rae 2008:63, 74-78) and in cognitive-constructive therapy (Voutilainen et al. 2010a). If we have a knowledge of psychotherapy, both would be expected. The first part of the conditional is crucial, because it suggests that their caution in generalising may be self-serving (Weiste & Peräkylä 2013:319-320). Their study began assuming difference (319), and subsequently 36% of psychoanalytic formulations were relocating (0% cognitive) and 16% of cognitive formulations were exaggerating (0% psychoanalytic). Given their assumptions and the fact that Peräkylä is himself a psychoanalyst (2008), I suspect these findings may be partly artefactual. These methods probably are predominantly analytic and cognitive, respectively, but such clean-cut results are fishy.

If we take psychoanalysis as “working with ‘puzzles’” (Venviläinen 2008:121-122), then there ought to be overlap with cognitive therapy’s “collaborative empiricism” (Beck et al. 1979:6-7). Davies’ (2009) study of psychoanalytic training gives us another reason to doubt this result by pointing up Paul Antze’s dramatic irony: “Via this device, patients are shown that they are under the sway of childish impulses that they neither fully acknowledge nor understand” (84). While the terminology differs (Socratic questioning vs. “Sophoelean strategy” [Davies 2009:84], dysfunctional thoughts/assumptions vs. unconscious motivation), I fail to see a substantial difference between these two interventions.

Peräkylä et al. acknowledge that different approaches have distinctive theories (2008b:6) and that in psychotherapy, the interaction and treatment theories are
“intertwined and inseparable” (23, their emphasis). They appear to be giving intellectual technology simultaneously both too much and too little credit: too much in that they believe it is inseparable from interactional technology; and too little in that they seem to fall under its spell, and, having been bewitched, miss the deep structural similarities. Clinical practice of any sort is immediate, or at least has exigencies and individual circumstances. Psychotherapists are shaped by their theoretical tradition, but they are also formed by their experience. Horwitz (2002) cautions:

“Many changeable factors, including the particular life circumstances of clients, their rapport with a particular psychotherapist, and the current credence of a form of therapy in a particular culture, always influence whether psychotherapy will be effective. … It is difficult, therefore, to use traditional scientific methods to evaluate whether psychotherapies achieve their goals” (183).

A desire to maintain or improve “current credence” motivates psychotherapeutic traditions to conduct scientific studies, which necessitates standardisation within and distinction without. Our focus now shifts to this scientific strife.

(III) Knowledge Creation is Competition

Science is often viewed as progressive and consensual. While elements of collaboration do exist within it, there is – as van Leeuwenhoek’s tale implied – an equal if not greater measure of conflict. I make five basic points in this section, namely that science is: 1) a field marked by coexistent consensus and contestation, 2) path dependent, 3) influenced by the material and intellectual technologies which gave rise to it (and is therefore historically and socially contingent), 4) a means to legitimate psychotherapy and other practices, and 5) being social and human,
contains a moral element. Competition is, in my estimation, the backdrop against which all these other factors play. We therefore begin our description of science with scholarly strife.

(III.1) “The basic pattern of intellectual life is not consensus, but disagreement.”

Drawing on a study of philosophers, Collins (1994) reminds us that, “The basic pattern of intellectual life is not consensus, but disagreement” (157). This process, Berger and Luckmann (1967) seem to say, intensifies in “advanced industrial societies” and becomes the status quo (85-86). MacKenzie (1993:10) appears to make a similar point when he suggests that “no [scientific or technological] knowledge possesses absolute warrant, whether from logic, experiment, or practice.” If any knowledge can be contested, then we need to examine when and why it does or doesn’t happen (MacKenzie 1993:10-11). I begin at this essential level, describing the dynamics of scientific collaboration and competition. We move from general to specific, from studies of hard sciences and medicine, and ultimately moving onto psychiatry.

Peterson (2015:1211) suggests that it is not simply the development of “genealogies of research technologies” (Collins 1994:162, 2000:538) that make sciences rapid-development and high-consensus fields. He argues that what makes the difference is iterative data collection and bench-building (1214). A comparative ethnography of laboratory practice in molecular biology and developmental cognition suggests that scientific progress is “a type of Schumpeterian ‘creative destruction’ that transforms
progress from within” (Peterson 2015:1219). Bench-building is a multi-stage process whereby local (and previously inexplicable, see *ibid*:1216) manipulations become stabilised and ultimately standardised, which then suggest the next generation of “possible manipulations” (see 1215, Figure 2). Further evidence of machinery not being the sole key to rapid-development science comes from pharmaceutical R&D, where increased efficiency has led to diminishing returns (cf. Scannell 2015; Scannell & Bosley 2016).

Competition might not seem obvious in this technologized setting. It is like GCHQ, lurking behind the scenes and only periodically emerging for clear inspection. “If we have the latest and greatest technology, we can ask more sophisticated questions,” said one molecular biologist (Peterson 2015:1212). What her comment and the idea of Schumpeterian creative destruction jointly imply is the constant fear of “anticipation” (Hagstrom 1975:71-2, 75-6) or being beaten to the punch. Atkinson, Batchelor, and Parsons (1998:262) remind us that “[s]cientific rewards – funding, prestige, fame – go to those who are first to observe a new phenomenon or produce a new result.” Scientists’ metaphor for this phenomenon of scooping, “somebody else ate my lunch,” therefore acquires a rather literal lamination.

One of Atkinson et al.’s (1998) ultimate findings seems somewhat paradoxical: “as the collaborative relationships dissolved, the competitive element in the research has simultaneously disappeared” (278). Arribas-Ayllon and Bartlett (2014), in a study of psychiatric genetics, seem to confirm Atkinson and colleagues’ (1998:260) “central claim that scientists experience collaboration as shifting dynamics of cooperation and
competition.” The switch by Wassermann from tuberculosis serology to syphilis, Fleck (1979:77-78) argues, came about because of his lack of competitors. Yet earlier, he states that “the development of the disease phenomenon requires decades” and relies upon “organized cooperative research” (22). Competition motivates individuals and collectives, and this generates a rough-and-ready cooperation whereby over time, new facts (and thus norms) emerge. Scientific revolutions may be turbulent, but Kuhn’s (1996) normal science is far from a smooth ride.

Shwed and Bearman (2010:818), like Atkinson and colleagues (1998:260), therefore suggest that an “everyday, normative level of contestation” exists alongside collaboration and makes it more difficult to suss out. What they propose are:

“[T]hree trajectories scientific propositions assume on their way through contestation to consensus among practicing scientists: (1) spiral, in which substantive questions are answered and revisited at a higher level; (2) cyclical, in which similar questions are revisited without stable closure (Abbott 2001); and (3) flat, in which there is no real scientific contestation.” (818)

Before we compare this typology to Gieryn’s (1999) descriptions of “credibility contests” and Peterson’s (2015) “bench-building,” we must bear in mind that “flat science can mean two main things” – either there is no consistent set of research questions, or that scientists have come to a decision which the public then contests (Shwed and Bearman 2010:835).

Gieryn’s (1999) conceptualisation of credibility contests doesn’t quite capture how conflict and consensus can cosy up to each other, but is fruitful nonetheless. Such contests occur when “bearers of discrepant truths push their wares wrapped in assertions of objectivity, efficacy, precision, reliability, authenticity, predictability,
sincerity, desirability, tradition” (1). Epistemic authority, “the legitimate power to
define, describe, and explain bounded domains of reality” (1), is one of the spoils
going to the victor alongside "jobs, fame, influence, nature" (15).

Gieryn (1999) outlines three types of credibility contest: expulsion (15-16),
expansion (16-17), and protection of autonomy (17). These categories can be
summarised as fights over whose approach is scientific, cage fights over the same
turf, and when outsiders attempt "to exploit that [epistemic] authority in ways that
compromise the material and symbolic resources of the scientists inside" (17; cf.
Parsons [1952:432-33] on biomedicine). We would expect protection of autonomy
to co-occur with either flat or cyclical patterns of consensus formation. Spiral
patterns, bench-building, and expulsion seem to describe different pieces of the same
process of knowledge creation. Expansion seems the hardest of these credibility
contests to pin down, but could fit with cyclical consensuses. MacKenzie’s (1981)
work is here suggestive. The biometricians and Mendelians’ debate over evolution
wasn’t based on evidence or factual incompatibility, but was a conscious choice
(Chs. 6 and 7, especially pp. 125, 132, 175; cf. Kuhn 1996).

According to Shwed and Bearman (2010), “[c]onsensus formation is a black-boxing
process: the weaving together of multiple elements of scientific propositions until
their internal divisions are well hidden” (820). This theoretical description confuses
facts and relations becoming taken-for-granted with a black boxing. Empirically,
however, their definition of consensus as the reduction in the number of salient
communities and the emergence of a “common, core community and many miniscule
communities” (822) seems much closer to the literature. Fleck’s notion of thought communities which restrict and thus guide sight (1979:101 on fact as “signal of resistance”) is perfectly compatible with this notion of consensus formation. Rose’s notion (1998) of truth “entails a social process of exclusion in which arguments, evidence, theories, and beliefs are thrust to the margins” (55) and fits equally well with both. Competition and consensus always coexist (cf. Fourcade 2009:284n105).

I believe we can boil Gieryn’s list of rewards (1999:15) to two fundamentals: attention/prestige (i.e. more enduring attention), and more material prizes (typically currency, e.g. grants – see Luhrmann 2000:165). Competition for these can become institutionalised, as it were. Appeals to diachronic (or traditional) legitimation typically come from more established institutes, whereas newer psychoanalytic training centres reach for synchronic legitimation (Davies 2009:41-3). The latter is achieved by “form[ing] alliances with centres outside the genealogical structure,” typically universities, thus gaining an ability to award degrees. For psychodynamic clinicians, the choice between prestige and security can come before they even begin accreditation.

While a wide range of factors influence a scientist’s choice of research subject and method (cf. Foster, Rzhetsky, and Evans 2015:876 for a list), these two incentives are mentioned again and again. Foster and colleagues (2015) explain the “essential tension” (878) between innovation and tradition in these terms: “Tradition is not pursued merely because of training; it is a reliable strategy to accumulate recognition. Innovation is not a happy accident; it is a risky gamble” (879). Even
perennial punching-bag Parsons (1952:432-33) allowed for such contestation within medicine (see his discussion of medical 'superstition' regarding Pasteur and Lister, pg. 433, and discussion of Sir William Osler, 448). Strong (1979a) indicates that physicians “do not hunt as a pack, but, like every other profession, are riven by differences of interest, expertise and ideology” (205; cf. Pickersgill 2014a:521). Perhaps this inherently competitive aspect of science has lead authors to assert that that “[m]edical systems should be viewed as never-finished, historically created cultural products-under-construction” (Gaines 1992b:6; cf. Rosenberg 2015:133).

Such statements contain some truth, and thus have the merit of urging us to research processes (Gaines 1992b:6). What they miss, however, is that this could be said of any science or human organisation. Berger and Luckmann (1967) urge us to address both the dynamics and the statics of society: a process is a thing, or at least must sometimes be understood that way in order that we might describe it.

It is perhaps a lack of appreciation that science is always provisory and none too peaceable that drove Pilgrim and Rogers (2009) to question why British psychiatry carried on. Pickersgill (2014b) focuses more on intraprofessional squabbles, suggesting that “[o]ntological anarchy is…. a response to the uncertainties inherent to dealing with antisociality in a psychiatric context, as well as an engine producing yet more ambiguity” (147). To argue with Pickersgill against Pickersgill (2014b), “different theories underlying neurobiological research into [PD] are not mutually exclusive” (2009a:49). The same paper stresses that broadly speaking “ASPD and… psychopathy are considered complex conditions by those who research them” (2009a:53-54).
Why did documentary analysis emphasise that “precise biomarkers… have not led to a fully biologically-characterized topology of antisociality” (2014b:162) and interviews “a developmental story of genetic and environmental factors” (2009a:53)? Existence of “a range of parallel trajectories along which research might progress” (Pickersgill 2014b:146) is better described not as “ontological anarchy” (or “multiple psychiatries,” Pickersgill 2012c), but less poetically as an “everyday, normative level of contestation” (Shwed and Bearman 2010:818). In my reading, Pickersgill (2014b; cf. 2012c) ignores the fundamental features of science and even his own evidence on psychiatrists as “ontological bricoleurs” (165, cf. Pickersgill 2009a, 2010a) to drive home his points on “co-production” and “the limits of technoscience” (2014b:165). Pursuit of prestige and competition for funding even emerge in his earlier work as influential in the growth of the neurosciences within psychiatry (Pickersgill 2010a:302).

Attempts at critiquing psychiatry occasionally demonstrate the competition both within and across sciences. Young (1995) cannot decide whether psychiatric science is like other sciences or not: both use probabilistic reasoning (266), and both have “fluid and usually contested” boundaries “between those results worth preserving and those that ought to be discarded” (268). An exception to the latter condition is if “the theory or hypothesis has attracted no attention” (ibid:268), i.e. there has been insufficient competition (e.g. Fleck 1979:77-78) or originality. Thus far, he and I chiefly concur. It is only his apparent divorce and degradation of psychiatric science relative to all others that causes contention. Other sciences use probabilistic
reasoning, but apparently psychiatry is doing it wrong. He argues that Type 1 errors are treated as a dichotomous variable, and Type 2 as continuous (266). No attempt is made to demonstrate that psychiatric science differs significantly (pun intended) from other disciplines. In short, I argue that he places psychiatry under the banner of “fallibilism” (265) as against falsificationism largely to have his name on something. Young (1995) classes the “continuity of nature” as being part of a “fallibilist perspective” (271). Is psychiatric science distinct or not? Or does the provisory nature of science render all of it suspect?

French CBT practitioners have historicised and Gallicised both their psychotherapeutic method and social phobia. They point to Paul Hartenberg and Pierre Janet in this connection (Lloyd 2006:244-245). These claims aren’t made simply as part of a circumscribed contest for clientele within France, but form part of a broader historical and international picture: “By overhauling the profession, [French CBTs] hope that Paris will return to its former glory and regain a place in top-level psychiatric research worldwide” (ibid:246). Lloyd underscores here the importance of self-interest (and national pride) in scientific competition. Facilitating international scientific cooperation can sometimes mask moves made with other motivations in mind. Warrant for the revisions for DSM-II and DSM-IV, for example, was ostensibly coordination with the ICD nosology (Kirk & Kutchins 1992:201, 209).

Kirk and Kutchins (1992:209, 215-218) point to the impassioned arguments of Mark Zimmerman against DSM-IV. Frequent revisions, to be succinct, impede the

Technological trajectories, both inside and outside psychiatry, form a self-fulfilling prophecy generated by interested parties (cf. MacKenzie 1993:168-169). Contestation and instrumental action can therefore be seen operating over both short and longer time scales.

Ben-David & Collins (1966) take us to historical change. They suggest that the first modern psychotherapy emerged from a combination of competition (in this instance, over status) and self-interest:

“[P]sychoanalysis… was created by a man who moved from the prestigious profession of scientific research to the relatively lower-status occupation of German medical practice; Freud attempted to maintain his status by trying to raise medical practice into a form of scientific research, and as a result created psychoanalysis.” (Ben-David & Collins 1966:459)

I argue that these two factors help to shape the multifarious modern psychotherapies as well. My suggestion is not that, say, Aaron Beck founded CBT purely out of egotism, but rather because he saw a gap in psychoanalytic theory. Filling in this

\textsuperscript{15} DSM-III was a ‘paradigm shift’ in moving from a prototypical description of mental illnesses to describing discrete disorders in terms of symptoms. Originally DSM-5 had hoped to include dimensional ratings for all disorders.
fissure empirically led him to a different means of doing psychotherapy. The factors combine in various ways at the emergence of different schools, but these are the two primary mechanisms leading to the emergence of psychotherapeutic technologies. Monopolistic competition is here underlain not by adverts, but by research. As MacKenzie (1981:219) states, “to say that evaluation is goal-oriented does not mean that it is necessarily inadequate, unscientific, or biased.” The past continually shapes the present, even in psychotherapy, a topic to which we turn now.

**(III.2) “‘Their’ knowledge was used in the construction of ‘ours’”**

MacKenzie (1981:226) explains that modern statistics grew out of its eugenist precursors, and warns that our knowledge is equally contextual. Psychotherapies today and classical psychoanalysis have the same uneasy relationship. Fleck (1979:20, 86, 100-101) regularly draws our attention to the influence of past forms of thought on those of the present. DSM-III represents a partitioning of everything psychoanalysts had treated into individual ailments (Horwitz & Mayes 2005:251). Path dependency is, crudely put, the idea that present knowledge is always impacted by the forms of knowledge which preceded it. This concept is crucial because it would predict both the narcissism of minor differences, and the minor differences of narcissism.

Path dependence is evident within the classical psychoanalytic conceptualisation of narcissism itself. Cotti (1998) suggests that Freud’s “history of the development of the libido” was grounded not in clinical observations, but rather drew upon 18th century English anthropology. She begins with his *Totem and Taboo*, and argues that
Freud recreated the “history of the development of the human visions of the world” in his theory of child development (ibid, see especially pp. 47-48). It would be all too easy to chalk this up to the Freudian system being “so constructed as to evade falsification” (Gellner 1993:189). A recent analysis of “millions of biomedical abstracts” (Foster et al. 2015:875), however, suggests that conservativism is ubiquitous.

Foster and colleagues (2015) catalogue different network strategies: including jumps (a proposed relationship “involving completely unexplored entities,” 881), bridges (“[l]inking entities from discrete knowledge clusters”), and consolidations (“[j]oining entities within the same cluster”). These latter two may be new (i.e. “not previously published”) or repeat “a relationship proposed before” (881; cf. 882 Figure 1 for a visualisation of these strategies). Overall, they found biomedical scientists to be fairly conservative, with repeats (which they equate with tradition) being “six times more frequent than new or jump strategies, which correspond to innovation (85.8 vs. 14.2 percent)” (886). Jumps were outnumbered by new bridges and consolations “by roughly the same proportion” (1.8 against 12.4%, ibid). “Citation-maximisation,” or what might be called attention-seeking, “supplies plausible motivation for one half of the essential tension, that is, the substantial fraction of scientists who choose tradition over innovation” (896). Prestige- or achievement-maximisation focuses more on the introduction of novel chemicals and “more [frequent introduction of] new relationships within knowledge clusters” (897). Conservativism and path dependency are, however, related but distinct concepts.
Scannell’s work (2015; Scannell & Bosley 2016) on pharmaceutical development suggests that one can be path dependent (focusing on industrialising testing) without being conservative (constantly improving the machinery for more brute force). What this implies is that conservativism is an individual relation, whereas path dependency is a group relation. Let us take a psychiatric example, neuroscientific research into psychopathy and antisocial PD:

“[T]he difference in utility ascribed to either the [Psychopathy Checklist – Revised] or the DSM-IV-TR for research ensured that one of these tools was elevated as more scientifically useful than the other, and the disorder they identified more important to research.” (Pickersgill 2011b:80)

Pickersgill indicates the existence of two broad research traditions, standardised by the use of one of these measures (cf. Pickersgill 2014b:154-7). Individual researchers can be conservative by using the expected tool to screen an appropriate sample, but are nevertheless constrained by the choice of the DSM to adopt Lee Robins’ behavioural criteria over Hare’s more heterogeneous approach. Most importantly for this study, these tool-centred traditions imply is that there is a link between theory and instrument, to which we move now.

(III.3) “The questions that we can ask are limited by the way we can ask them”

“The questions that we can ask are limited by the way we can ask them” (Peterson 2015:1212). While this is particularly true for Peterson’s molecular biologist, we can readily extend it to every area of intellectual life. Advances in postwar American economics, Fourcade (2009) suggests, “relied extensively on the success of new formalizing technologies” (91). Psychiatric technology of the sort Pickersgill
discusses, such as the DSM and Psychopathy Checklist – Revised (2014b:154-155) may not be quick to change, but nevertheless constrain the researcher’s sight (cf. Bowker & Star 1999:102-106 on interpretation being “enfolded” into the ICD). An American economist called for “[fuller] utilisation of the concepts and hypotheses of economic theory as a part of the process of observation and measurement” in order to help them better understand business cycles (Fourcade 2009:86). This restriction owes not only to their being shaped by earlier technology, such as Hans Eysenck’s Maudsley Personality Inventory (Pickersgill 2014b:149), but to their different implicit theoretical assumptions. Even anatomical and histological atlases hold “representations [which] inscribe implicit instructions for how to look and what to look for” (Atkinson 1995:69). We find here some independent confirmation of MacKenzie’s (1981:224) conclusion that “[a]ll explanation, perhaps even all description, in the history of science is inevitably theoretical, and this is no less so if the theory is implicit.”

MacKenzie’s monograph (1981), as previous citations have hinted, suggests that our assumptions affect our instruments. Statistics is disputably the chief legitimating force within modern science, but simultaneously we owe its focus on statistical dependence to the eugenicist concerns of early statisticians (71). Parsons portrays ideology (“the area in which their values are integrated more or less successfully, with their cognitive conceptions of the objects involved”) as “merging into science” (1970:296). If we follow Fleck (1979), a fact is “a stylized signal of resistance in thinking” (98), then every fact implies a norm.
Inevitably this argument is misapplied, and a local, scientific norm is conflated with a broader one. Nuckolls (1997b), for instance, insists that “Axis II [PDs] are cultural commentaries on American value orientations and their realisations in gender” (253). His discussion of U.S. psychiatry as a “reflect[ion] and realis[ation]” of “a dialectic of opposing values” (270) may not use the language of “co-production” or “co-constitution” (e.g. Pickersgill 2013), but also presents its presumptions as conclusions (cf. Berger 1965:33 in this connection). Lester (2013:73-74) suggests that borderline PD, one of Nuckolls’ favourite categories, is sometimes misused, but that this needn’t always be the case. Her main point in this section is: if we ask deconstructionist questions, we get deconstructionist answers, whereas “if we allow that, at least in some cases there is some basis for the diagnosis of BPD, we have to then ask what that basis is” (73). Fourcade (2009) indicates that “it is never as necessary to affirm the existence and proper character of a boundary as when it is fuzzy and porous” (125). Our eye now wanders in the direction of how boundaries are defended in psychiatry.

(III.4) “[T]he quantifiable and measurable techniques that were the source of medical legitimacy”

Berger & Luckmann (1967:112) propose that science legitimates the entire “symbolic universe” of advanced industrial societies. American economics relies upon its scientific standing in order to retain its prestige and place in that society (Fourcade 2009:Ch. 2, see summary p.128). It shouldn’t shock, then, that (ecumenical) psychiatry relies upon science to direct and legitimate its practices (Greenberg 2013:153, Young 1995:271-272; cf. Gellner 1993:26 on psychoanalysis,
also Hunter 1991 and Wright & Treacher 1982b on medicine). We return again to Parsons, who describes medical science as “not... a single theoretically integrated discipline, but a field of application” (1952:455, emphasis mine). Applied science must, however, conform to the norms of the wider scientific community (Fourcade 2009:260 provides an example; cf. Horwitz 2002:184-187). To an extent, it must consider the public perception of what makes science respectable, which varies from nation to nation. Lakoff (2005:149-150) mentions the association between biopsychiatry and “the violent 1976-83 military dictatorship” cutting its moral and scientific standing in Argentina. The connection between applied science on one hand, and scientific and public norms on the other, holds at both micro and macro levels.

Consultant psychiatrists, for instance, often advised their colleagues to use a standard technology (psychopharmaceuticals) “for the latent and symbolic function of increasing the probability of acceptance of psychiatry by nonpsychiatric physicians, thus reducing status marginality” (Johnson 1985:275). Several researchers, notably Kirk and Kutchins (1992; Mayes & Horwitz 2005) have argued convincingly that the main purpose of the DSM-III was to reunite psychiatry with medicine by giving it an ostensibly more scientific footing. Horwitz (2002) contextualises this by pointing to the historical shift from case studies to the (randomised) controlled trial in the first half of the 20th century: “To maintain its position as a medical specialty psychiatry was required to replace the subjective, intuitive, and broad standards of dynamic psychiatry with the quantifiable and measurable techniques that were the source of medical legitimacy” (185). Discrete disorders allowed clinicians to conduct RCTs
and thus reap the rewards due interventions backed by appropriate evidence. Kirk and Kutchins (1992) suggest that the kappa statistic “transformed the problem of reliability… into a technical problem to be solved by research specialists” (44). The diagnostic technology of DSM-III (and onwards) is, by their account, aimed at modernisation, and establishing technical rationality (ibid:49-56, 220-223, 228-238).

In their earlier work (1992), the critiques are tough but fair: essentially the DSM pays lip-service to science but doesn’t quite deliver. Reliability, the saving grace of DSM-III and forward, was never conclusively demonstrated but came to be the official story nonetheless.

In general, to be recompensed, one must demonstrate some type of efficacy: “States, corporations, and scientific institutions require numerical justifications to prove that the policies they implement actually seem to work” (Horwitz 2002:185). Davies (2009:46-49) argues that the decline of psychoanalysis was in part due to rising doubts about its scientific status. In a sense, psychodynamic therapies in the US and UK are refighting old battles. Germans (e.g. Leichsenring & Rabung 2008), perhaps because of their growing precarity, adopted the methods of evidence-based medicine as a whole to maintain their scientific status. This particular meta-analysis has become a favourite among American clinicians, if the number of citations it received at the 2013-2015 NASSPD conferences are at all indicative.

Sometimes science is basic, meaning that there will be a definite lag between discoveries now and useful applications. Pickersgill (2011b) uses this frame to discuss neuroscientific research into antisocial PD and psychopathy. He correctly
identifies neuroscience as a scientific fashion (2011b:459; cf. Parsons 1952:467-469 on medical fads), and elsewhere (2014b:157-161) concludes that basic neuroscience and genetics research legitimate current psychiatry. In both cases, however, he ultimately mistakes the provisory and uncertain nature of science for “ambivalence” (2011b:460-1) or “ontological anarchy” (2014b:passim). Pickersgill’s professional scepticism (cf. Strong 1979:201) may legitimate his work as STS, but ultimately one wonders if he is only resisting biology to keep his own sinecure secure.

A classical multiple audience problem exists: the practitioner is caught between insurance, the broader society, the patient, their fellow clinicians, and if this case is part of a study, the research community (cf. Bowker & Star 1999:141-148 on the ICD, and Whooley 2014:103 on DSM). I would suggest that in the last case there is less of an issue, as ambiguous cases are typically screened out. The average patient, however, does not fit neatly into one box and one box only (Whooley 2010:458-460; cf. US-CPs 7 and 11), nor does the typical clinician think in terms of checklists (Cooksey & Brown 1998:538; Gaines 1979; cf. DE-P-1). Brown (1987) suggests several remedial activities in dealing with the essential detachment of DSM from everyday clinical practice. These include “humour, sarcasm, and imagined alternatives” (38-40), and “minimisation and normalisation” (40). In a later study, Whooley (2010) lists work-arounds employed by psychiatrists, including “alternative taxonomies” (459-460), “fudging the numbers” (460-462) by under-diagnosing to avoid stigma or over-diagnosing to enable reimbursement, and “negotiating diagnoses with the patient” (462-463). This multiple audiences problem has broader repercussions, however.
“[B]oth the continued centrality and contestation of behavioural and emotional ills” are assured by four continuities suggested by Rosenberg (2015:133). First is the mismatch between “specific” and “mechanism-oriented” understandings of disease and the actual (“cultural”, “bureaucratic”) work done by clinicians in their management. We also encounter “a never-ending negotiation over agency and responsibility” (133-134), and the embedding of diagnoses in “a bureaucratised and highly institutionalised society” (134). Finally, “psychiatry and its concepts bleed constantly and unavoidably into the larger culture” (134-135). What the multiple audiences problem ultimately means is that psychiatry acts as a mediator, “a kind of canary at the pitface of cultural strife” (Rosenberg 2015:129). We move now to morality and psychiatry, fully cognisant that it “is a science, a technology and a profession” simultaneously (Manning 2000:634).

(III.5) “Work violating them may well be seen as wrong and subject to sanctions”

Morality is a strange case for scientists, both basic and applied. Scientists judge one another’s and their own practices as right or wrong, and are also (somewhat) subject to outside ethical assessment. The basic ethical principle of science is to accept well-documented theories and findings (despite competition), while simultaneously acknowledging their tentative nature (Parsons 1952:353-354). Scientists, doctors, and psychotherapists are all expected to judge what is harmful and what is not for their subjects, clients, and even for humankind. In their official capacity, however, they should refrain from adjudicating right and wrong in the same populations. We
have then four levels of moral evaluation: self, peers, clientele, and the broader society.

Just being a scientist carries social and moral status. According to Luhrmann (2000), “[f]or many young psychiatrists, … the moral authority of science outranks the moral authority of helping people one at a time” (181). The individual might not achieve much, but “every scientist participates in the aspirations of the whole” (ibid:181).

But as we will see later sometimes the norms and findings of science clash with treasured myths:

“[A psychiatric researcher] was horrified that a belief in what should be the case should override what science had determined to be the case: that some women had premenstrual periods that caused them to experience symptoms of mental illness.” (Luhrmann 2000:180)

It is worth noting that this researcher is a woman. Contra Kutchins and Kirk (1999), in the case of late luteal phase dysphoric disorder it was not DSM “abandoning scientific procedures in their haste to invent new diagnoses” (88). As these social workers show, the most effective weapon against science is science, or claims thereof.

We would expect scientists to have some basic norms in common, due to their shared rituals (Collins 2000:26, 40-42, 73-74). If nothing else, the ritual of peer review guarantees a certain minimum morality in science – though any social sanctioning system is far from fool-proof. Scientists also review each other’s work collectively, for instance in journal clubs (Peterson 2015:1215-1216). Such highly localised rituals socialise students, and reaffirm the laboratory community itself, as
well as its connection to a broader field (here, molecular biology). “Inexplicability is a defining characteristic of the research frontier,” but “only results that remain tethered to particular researchers or labs come to be seen as deeply dubious” (ibid:1215-1216). Quantity and quality of communication between different research groups widely varies: contacts may be repeated until a particular technique is generalised with the same results across labs (Peterson 2015:1216). Competition casts its shadow even here: “[S]cientists reported sharing those resources they felt would be of limited benefit to other collaborators and protected resources such as probes by rationing their distribution, at least until they’d published” (Atkinson et al. 1998:270).

The system operates mainly through positive reinforcement and the competition for these rewards (funding, prestige, citations). A successful method may lead to a generation of derivative manipulations (see Peterson 2015:1215, Figure 2), and also potentially new ethical quandaries (Pickersgill 2012b). Innovative or definitive findings may in turn lead the field to a higher level of abstraction (Shwed & Bearman’s [2010:818] spiral patterns). MacKenzie (1981) reminds us of the possibility of punishment:

“After techniques or theories have passed the test of communal evaluation, they take on within the community of statisticians the status of social institutions: they are taught as correct, work in accord with them is rewarded, and work violating them may well be seen as wrong and subject to sanctions.” (216)

In my reading, MacKenzie implicitly highlights the prestige that can come to those get there first, as well as the rewards of sticking with the resultant tradition (Foster et al. 2015, especially p.896). Atkinson et al. (1998:271) remind us that sanctions may
even come during the process of competition, as “[r]esearch groups draw disapproval if they are felt to have abused shared information.” Such betrayals result, as we’d expect, in shifting alliances (ibid:271-272). Shared morality and solidarity travel together (Collins 2004). American economists who share “a common set of practical rules… regarding the proper way to ‘do’ economic science” and thus form a community (Fourcade 2009:77) are exemplary. But how do outsiders view psychiatry’s moral standing?

Psychiatry is cast as a moralising force, an agent of social control (cf. McGann 2011, Scheff 1999, and any of the papers in Rapley et al. 2011). In Germany, for instance, psychiatry was (and possibly still is) associated with the mass-kilings of the mentally ill by the Nazi regime and so seen as “not really respectable” (Payer 1989:96). American psychiatry is far from being seen as pure. Kutchins and Kirk (1999: Ch. 6) present selective evidence to make it seem as though borderline PD exists only to cover for psychotherapists who have sex with their patients (cf. Lester 2013 for a counter argument). On this scale, all three aspects are indicted: science, profession, and technology.

Let us begin with the intellectual technology, the broad concept of mental disorder, since this is usually the starting point for arguments against psychiatry as a technology, science, or profession. I follow Wakefield (1992), who proposes:

“[A] hybrid account of disorder as harmful dysfunction, wherein dysfunction is a scientific and factual term based in evolutionary biology that refers to the failure of an internal mechanism to perform a natural function for which it was designed, and harmful is a value term referring to the consequences that occur to the person because of the dysfunction and are deemed negative by
The sociological instinct would be to problematize notions of scientific, factual, and natural, if not still more words in this pithy definition. Science is neither flawless nor limitless, and facts are always subject to later revision in light of new evidence or changes in social relations. I find it pure hubris to deny nature’s existence and that biology plays no role in human behaviour. Additionally, values come into play with demonstrably physiological conditions such as low blood pressure, which is regarded “a German diagnosis” (Payer 1989:86-90). Even diseases that few would claim to be constructed, such as HIV, contain a value element (Wakefield 1992:374; Parsons 1952:431). It is my duty to be Durkheimian and assert that to be human is to be moral.

Goffman points out that psychiatry has gathered a large body of data on focussed interaction (1961b:8) and social delicts, particularly interactional errors (1963:3; 1967:137-148). He (1961a:363, 1961b:24-25), and later Gaines (1979), would suggest that usually these situational improprieties first come to the attention of their immediate environment. “Mental Symptoms and Public Order” appears to open with an analysis not unlike Wakefield’s above:

“The objective of psychiatry all along has been to interpose a technical perspective: understanding and treatment is to replace retribution; a concern for the interests of the offender is to replace a concern for the social circle he has offended.” (Goffman 1967:137)

Violations of the rules for face-to-face engagement could, I think, be safely counted as a dysfunction. Goffman (1967) “know[s] of no psychotic misconduct that cannot be matched precisely in everyday life by the conduct of persons who are not psychologically ill nor considered to be” (147). In short, he shares Wakefield’s
(1992; Horwitz & Wakefield 2007) concern with our appreciating the contextual factors driving the person’s actions and the environment’s response.

Drawing from "about a hundred transcribed intake interviews", Bergmann (1992) determines that West German psychiatrists use "a range of techniques... for marking his restricted access to the events or circumstances he is speaking on" (142). The precise verbal manoeuvres employed are presently unimportant. While he shares this basic recognition that psychiatry has a helping (in his words, medical) and a moral element, he sees this as much more sinister. “The seemingly innocent, helpful, and affiliative utterances with which a psychiatrist attempts to induce a candidate patient to disclose his feelings and opinions have structurally an inbuilt hidden or veiled morality" (156). He argues that this “veiled morality” can cause a sort of iatrogenic reaction as the pre-patient attempts to save face and end in the individual’s being sectioned (157). What we find here is a simultaneous censure of both the profession and its interactional technologies: “Psychiatry is an institution caught and twisted between medicine and morality; and detailed analysis reveals that this contradictory structure materialises itself at the level of turn-by-turn interaction in the various manifestations of psychiatric discretion” (158). There is certainly some truth to this critique, but it begs the question, is it possible to judge something’s harmfulness without also assessing its morality? Could this claim therefore be extended, albeit in a weaker form, to medicine as a whole?

(IV) Discussion

Moving forward, a few main points should be kept in mind. Diagnosis, treatment,
and science are all highly contextual, partially ritualised, and defined by self-interest, competition, and conceptualisation. These processes are interdependent. Diagnosis draws on an intellectual technology, and this conceptualisation leads to a particular set of interactional strategies. Treatment feeds back into diagnosis, and these interactional technologies are often standardised to allow for scientific comparison. Finally, science legitimates and often alters the intellectual and interactional technologies deployed by a theoretical tradition. Overall, the process is driven by competition, meaning that science itself is not purely rational.

Assessment, and intellectual technology more broadly, are shaped by historical, social, and psychological milieux while to a degree itself creating context. Though it is now a truism, the reader ought to recall that diagnosis is a process. These ways of seeing are theory-laden. I argue that models don’t just distort, but that they help guide the practitioner in relating to others in their daily rounds. In terms of treatment, three main similarities across psychotherapeutic schools were introduced: (1) the conversational cycles by which therapists come to clinically relevant material, (2) their means of dealing with emotion, and (3) how empathy and sympathy emerge.

Competition and collaboration coexist in science, which is fraught with similarities due to a shared history. Scientists’ tools are theory-laden, and thus limit the types of questions they can ask. The legitimating power of science means it is a valuable resource in the competition amongst scientists for attention, heirs, and monetary rewards. Morality is inherent in all human endeavours, even science. Critiques of psychiatry overlook this aspect of everyday life. I’ll now consider how the research
was conducted, beginning with my own possible impact on the findings given my status as research instrument.
Chapter 3: Psychiatric Kennerschaft and the Wissenschaft of Psychopathology: How A Sociologist Studied Narcissism

(I.) A Prideful Prelude

A staple of scientific speech is a (more or less) thorough description of one’s instrumentation and its calibration. Qualitative researchers can be cornered: too much autobiography and rightly be accused of narcissistic self-indulgence, or too little and we face questions about the impact of our selves on the research. Given that I am the chief observational and interpretative engine, a scanty sketch is required to properly contextualise my findings (cf. Ainsworth-Vaughn 1998:19). Idiosyncratic elements are arguably weightier than theory, as who we are as people determines which thought style will appeal to us, and how we will adapt and elaborate it (cf. Fleck 1979:111-125, esp. 120).

I began this work having ‘carried’ various psychiatric diagnoses for nine years. The constant has been depression, though social anxiety and Asperger's have drifted in and out of the conversation. Ultimately, I saw an NHS expert on autism spectrum disorders on the advice of a therapist, who pointed out that some of the key elements were absent. I knew this psychiatrist was decent when he answered my statement that I had some traits of Asperger's with, “As we all do.” My undergraduate studies began in earnest only after several suicide attempts and a stay on a psychiatric unit. I came here as an ex-mental patient with a belief that psychiatry was less care and more social control.
I have been medicated throughout. Bupropion (Zyban) is not indicated for use as an anti-depressant in the UK, and therefore needs a psychiatrist's say-so to be so dispensed. When I exhausted my supply of Bupropion, I became something of a recluse. I slept on the sofa, wearing daytime clothes if I’d left the flat, and filled my days with quiet crying and watching TV shows online. Enough was enough, I said, and landed at a sort of psychotherapy boutique where I felt bad about arriving sweaty. Here I obtained that coveted recommendation to an NHS psychiatrist for evaluation.

My GP prescribed me Trazodone as a secondary medication as a stop-gap. I overdosed on this one March morning, feeling overwhelmed by my responsibilities as a tutor, apparent lack of progress towards the PhD, and the stress of suing my former letting agents. Needless to say, once I saw the NHS shrink, I was back on the bupropion bus. He also gave ‘psychosocial support’ by suggesting Edinburgh psychiatrists I could speak to about my research plans. With the smell of the secure unit's lobby making me certain I'd be sectioned, I waited for forensic psychiatrists who took me into their off-unit offices and meeting spaces for background interviews.

My application to the Scottish Institute for Human Relations (the local psychoanalytic institute) yielded a recommendation around then. Her office felt claustrophobic and bare, and taking the bus to Leith was an ordeal because I always dreaded getting lost and missing my session. We never got past the consultation
phase as she wanted me to be able to commit to at least six months, and I was due to leave for fieldwork in a few months. (At that time, I still naively thought it would be weeks.) Her eye was sharp, and she was able to handle my hackles in a way unlike any past clinician.

When I began my North American fieldwork, I arrived with only one month's worth of psychopharmaceuticals and an overoptimistic belief I'd have my interviews done in six weeks. I spaced out doses in order to stretch my supply, but my mood was getting worse. Even with two cats and my parents for support, throwing back the bedsheets was on par with going over the top. My mother insisted that I go see my old GP, a doctor at a sliding-scale clinic in one of the city's poorer (but rapidly gentrifying) neighbourhoods. That doctor, one of the first I'd felt actually respected me as a human being and trusted me as a (less than equal, as I lack medical training) partner in my treatment, was out of town. Another MD saw me, administering the PHQ-9 (a short self-report measure of depression) and speaking with me at length. She thought my meds needed adjusting, and wanted me to see a psychiatrist as soon as possible. The possibility of my going inpatient was raised, but fortunately not pressed.

I went into community care, seeing a social worker for psychotherapy. He was affable, primarily interested in hypnotherapy but conversant in talk therapies. From here, I was recommended to an intensive outpatient programme (IOP) run by the same medical system. I was (and likely still am, by psychiatric standards) an overdose risk, so they wanted me to be closely monitored as they changed my meds.
The doctor taking my history in advance of IOP seemed oddly aloof - mixing a sort of Freudian abstinence with the mechanistic treatment approach of a bio-psychiatrist. (Though the ‘atheoretical’ approach of DSMs III through 5 was known to me, it was only then that I really understood why some of my informants had referred to these somatically oriented clinicians as “descriptive” psychiatrists: with this physician it felt like what mattered was presence/absence, the observable, and not context.)

IOP consisted of three hours every Monday, Wednesday, and Friday. Each day was further divided into hour-long blocks. How the hours were spent varied wildly, dependent on what staff were responsible for the session. Most of the staff were social workers, excluding the nurse heading IOP and the two psychiatrists between whom the patients were more or less evenly split. Far and away the favourite hours were those spent on meditation or relaxation techniques. Visualisation was the dominant means: the harsh fluorescent lamps would be shut off, the disruptive clock removed. Least popular were the unfocused hours spent with a mostly retired social worker. We grumbled that all she did was shoot the breeze with us.

Another social worker had a clear psychoanalytic bent, and encouraged a sort of Gestalt approach in which one patient would speak about their problems and the rest of us would offer our advice on how to deal with the situation. Other times we would simply read worksheets aloud on coping skills or giving facts about mental illness. Craft-oriented hours, such as having us make collages depicting our identity as we perceived it, cropped up. “Group,” as we called IOP, was such that people felt genuine sadness about the “graduation” of others from the programme. Cake or
doughnuts were a staple of graduation days, and the “graduate” would usually exchange mobile numbers with or give their Facebook name to all interested (if they hadn't already done so).

Journaling and setting biweekly goals related to our treatment were two main therapeutic tools bolstering the sessions. A daily chart in which we ticked off our accomplishments in certain areas (e.g. “Letting go” in the “Spiritual” needs domain) complemented the journal. The sociologist in me could see that such self-reports made our mental illness measurable, they quantified our “symptomatic reduction.”

On entering IOP, all of us were given a folder containing several workbooks on coping skills, a blank journal, a meditation and relaxation CD, descriptions of the programme, and a copy of our treatment contract. (This contract outlined treatment goals and our plans for dealing with suicidal thoughts, among other things.) Again, the sociologist in me could spot that this was the institution protecting itself from litigation.

In the past, group therapy had not worked well for me – possibly because of my misanthropy. This time, however, something was different. I didn’t take the exercises and homework as childish or as efforts to control me, but engaged with them instead. It wasn’t as if I spoke often, but when I felt I had something to say, I piped up. “Group” brought two other changes, one in diagnosis and the other in medication. My IOP psychiatrist's initial suggestions for additional psychopharmacological interventions were atypical anti-psychotics. I was resistant to these for two reasons: first, he said they might cause weight gain, and second, I
knew about the risks of tardive dyskinesia (uncontrollable motions coming after prolonged use) with such drugs. We spoke further. After hearing that I sometimes did not want to do anything, not even sleep, my IOP psychiatrist thought I might have bipolar II and prescribed lamictal (lamotrigine, an anti-convulsant used as a mood stabiliser with bipolar II or cyclothymia and in cases of resistant depression). My Scottish psychiatrist gave me a brief test for bipolar in our second appointment after I returned from America. He repeatedly said that though this questionnaire was “not diagnostic,” he said that my “American psychiatrist friend may have been onto something” and suggested I read up on cyclothymia and bipolar II.

Overall, Group and my subsequent experiences led me to take in earnest what are taken as some of the core truths transmitted in the catechism of the sociology of mental health:

1) A mental illness diagnosis changes the relationship of an individual to self and others. On my last morning, I spoke with the head of IOP, expressing my doubts that I didn’t know what I was without my diagnosis, and that I feared I had no “real” identity underneath. He assured me that we aren’t our illnesses, sticking once again to his trusted metaphors of diabetes and heart troubles and pointing out that we don’t equate these individuals with their ailments. We see here the negative side of diagnosis.

2) Such a medicalization can actually cause a person to deteriorate as they adopt the role and no longer seek alternative ways of dealing with the circumstances created by their psychiatric symptoms. I had the hardest time facing and internalising this
truth, though IOP stressed how crucial it was to learn coping skills to deal with stressors in everyday life. Here we see the most fascinating feature of my IOP from a sociological perspective: staff in many ways normalised our illnesses and underscored that everyone has difficulties in living, and that all of us fall down sometimes. Compliance with medication (to use the sociological propaganda) was, however, given great weight as being part of “taking responsibility for [our] illness.” As far as I knew, all the other patients were also on medication. None of the others, however, seemed to see any contradiction between these two parts of the biopsychosocial model implicit in this programme.

Describing my psychiatric history to a friend, my growing doubts about psychotropic medications crystallised. At first, the psychoanalytic notion that all meds did was to mask symptoms (brought to my notice first by Light's [1980] depiction of a psychiatric residency) seemed laughable, quaintly obsolete. My research – and the experiences in Group - caused the doubt to coagulate and stabilise, scabbing over this hole in my thinking. I had an epiphany moment where I suddenly knew that I had internalised this depressive role and ceased questioning it.

3) Mental illness may have social as well as genetic, neurological, and psychological (or intrapsychic) causes. I follow Wakefield in saying that though psychiatric disorders share a hazy boundary with normalcy, they are nonetheless real (see e.g. Horwitz and Wakefield 2007:17 for a list of other fuzzy but real distinctions, such as adult/child). Goffman wrote “Were there no such notion [of mental illness], we would probably have to invent it” (1972:335) and “mental hospitals are found
because there is a market for them” (1961a:384). By no means do I think psychiatric care is uncomplicated or an unmitigated good. In our haste to prove social science's ongoing importance, however, we cannot dismiss the good psychiatric professionals do or that sometimes a mental illness is both a label and a reality. I have been inside an MRI and undergone cognitive and psychological testing – what they measure may be debated, but not their meaningfulness.

Unrelated to my own psychiatric history, I ceaselessly felt split: I was attempting to become both a psychologist and a sociologist at the same time. It often seemed an insurmountable challenge to enter these two very different worlds. In sociological terms, I felt like a prototypical marginal man – walking in two worlds, but belonging to neither. Only in rare moments – reading Hikikomori (Saitō 2013) on the floor of a subway stop after ASA, first delving into Karl Jaspers in my flat in Stuttgart, and digging into Schmidbauer's (2005) Therapy on Demand in a café on a grey November afternoon – did I feel these worlds could somehow be joined or even bridged.

While we can class all three as psychodynamic, I don’t believe this trait was why they moved me so. Saitō (2013) stressed the social ecology of withdrawal, and how psychotherapy wasn’t limited to the individual. He showed a way in which psychiatry could blend elements from different schools of thought into a seamless whole. Karl Jaspers treasured the fundamental humanity of each individual patient while also valuing a scientific approach. He was, in my reading, equidistant from the neo-Kraepelinians and some cloistered, wholly hermeneutic psychoanalysts.
*Therapy on Demand* was not as religious a reading experience as the others, but equally challenged both biopsychiatric and analytic orthodoxy. His stinging wit and a single simple idea imprinted in my mind: namely that therapy needn’t be a one-off, but could consist of a series of learning experiences that helped an individual deal with crises. A great deal of time was nevertheless spent in ignorance, wondering what I was even doing. On a date during my American fieldwork, I was asked what I was researching beyond narcissism. I had no answer – I could only sit opposite this woman, dumbly resounding the same cry of “Narcissism,” only able to add the hollow rejoinder, “I’m just studying narcissism.”

My solitude was lessened somewhat through attending the 2013 American Sociological Association conference in New York City. Hearing paper after paper convinced me I had some attachment to the field, though I in some way remained alienated. In medical sociology and mental health, I felt insufficiently political – it sometimes had the flavour of a McCarthyist or Stalinist closed session where enemies of the State (here, doctors and psychologists) were judged in absentia. Those not busy supressing dissent gave themselves over to the star-gods and secondary analysis of surveys. Sociology of knowledge can turn into navel-gazing and seems to be riddled with philosophising passed on to an unsuspecting audience. Between these rather disparate approaches, it was difficult to see how I fit any of them – though comforting to know that there were others grappling with topics and research problems like my own.

Until that fateful ASA meeting, I identified more with psychoanalysis than sociology.
I even attended a mini-conference on “Psychodynamics and the Social” in order to see how others had attempted to integrate the two fields. Everyone there, with a few exceptions, was a dyed-in-the-wool full-Freudian, and worse still – they attempted to serve two masters with incompatible aims: Marx and Freud. The day was filled largely with references to the Frankfurt School, and some rather outlandish statements. “Rage, as we all know, can exist outside human beings” (paraphrase) was heard in a talk on the “deeper” motives of post-foreclosure house vandalism. I wanted nothing to do with psychoanalysis, at least this breed thereof – especially after I learned of the huge time and financial costs of analytic training.

I figured I might as well become a psychiatrist or take a second PhD in clinical psychology. Almost the entirety of my first two months in Germany was filled with such fantasies of a flight into a field with shared knowledge measurable in books and not just sentences. It took still longer to find a sustainable stance towards social science and psychopathology. Only after about a year did I realise I could write a sociological analysis which took psychiatry seriously, rather than as a cartoon villain.

(II) Ethnographic Interviewing and Grounded Theory

Data collection was led by a series of semi-structured interviews with psychiatric professionals, conducted in both North America and German-speaking Europe. Though interviewing is not ethnography, an ethnographic approach to interviewing (Spradley 1979) was taken. Ecks & Kupfer’s (2014) notion of habitography is more applicable, as my analysis concerns psychiatric professionals’ “prolonged and repeated patterns rather than one-off events” (2). I hope to offer insight into the
diagnostic, psychotherapeutic, and scientific habits of practitioners surrounding pathological narcissism. My general research-orientation could be lumped with grounded theory. The findings to date helped to sharpen and even shift the focus of study as it went on. Such a tack was taken both across the research as a whole, and within individual interviews. If a comment seemed to hold potential, it was pursued – though some such remarks were but siren songs. The analysis was astonishingly archaic, utilising no software beyond a word processor. I created excerpt files (Weiss 1994:157), and worked from these.

Psychoanalysis enjoyed a long heyday in the US, but was now far from its peak. In contrast, German psychoanalysts were still taken seriously and reimbursed by the state-funded health insurance. This distinction, along with Germany’s greater collectivity-orientation and American individualism, led me to select these two countries. Additionally, relatively few studies have been conducted comparing psychiatric illness in two developed countries. My data ultimately suggested that it was one's theoretical orientation which mattered more than the national context in which one worked. Canadian, Austrian, and Swiss-German respondents were therefore recruited. The historical connections between Germanophone and American medicine partially justify this:

“About two-thirds of the Americans abroad (approximately 10,000) were drawn to Vienna and went no further. Another 20 per cent studied chiefly in Berlin (perhaps 3,000). Not more than 10 per cent enrolled in the other universities in Germany (about 1,500) and less than 2 per cent registered for study in the universities in Switzerland and Austria-Hungary outside Vienna (not over 200)” (Bonner 1987:39).

When my informants had worked in multiple nations, they were questioned about
this if time permitted.

By focusing on therapeutic approach, I was able to capture the diversity inherent in the field. Glaser and Strauss (2006:56) write that, “maximizing differences among comparison groups, increases the probability that the researcher will collect different and varied data bearing on a category, while yet finding strategic similarities among the groups.” I interviewed assessment specialists who didn’t treat patients, and practitioners who believed either that NPD did not exist or that it was so rare as to be subsumed under antisocial/dissocial PD. Social and personality psychologists were also approached in both contexts, due to their contributions to the scientific literature on narcissism.

Interviews were complemented by a broader, sociological re-reading of the clinical literature (Pickersgill 2010, 2012a) on NPD. I focused on treatment manuals, “clinical theory,” and studies either authored by the informants or pointed to them as essential to understanding narcissism. Most experts had a university appointment, and thus this method served as a sort of reverse “informant-check,” allowing me to see if and where they had deviated from the official line they offer in their scientific publications. Treatment manuals had a similar importance as they are often the recipes utilised in everyday clinical action. During the course of my work, I came to hypothesise that these clinical cookbooks would be one of the flashpoints of tension between assessment and treatment. This narrowing was also in some measure empirically determined. Though narcissism is comparatively understudied (relative to, say, depression), there are still numerous threads of research and many hundreds
of articles. An informant who was at the time of our discussion working on a PhD in clinical psychology was baffled by my question regarding three key works on NPD cited this, and could only respond by referring to divergent strands. Some approaches (e.g. Jungian, mentalization-based treatment) are given short shrift in favour of my respondents’ therapeutic schools.

First, my interview schedule was modified in advance of the interview if I had access to writings by that particular informant. An ethnographic approach to interviewing, however, seeks to understand the world being researched in native terms (Spradley 1979). As such, questions of comparability were settled empirically. I gave multiple plausible interpretations and pointed to the literature where possible, on the principle that “objectivity cannot be achieved by one researcher” (Ainsworth-Vaughn 1998:20).

Separate interview schedules were created for two people I interviewed at American insurance companies and an actress playing the role of a borderline patient in training demonstrations. The “cynics,” as I took to call those who doubted the existence of NPD as a discrete entity, required some rejiggering of my queries. Substantively, however, the questions cut to the same quick. Two respondents requested that no interview schedule be used. Both individuals were German (but of different orientation), and the psychoanalytic clinician was the only informant who declined to be recorded. Fieldnotes of that interview were composed immediately in the two hours following our discussion. A call to decline my interview request on the grounds that the practitioner in question was now retired was nevertheless highly
informative. I captured the contours and wrote down what exact quotes I could remember immediately after hanging up.

I transcribed all the interviews. Laughter was surprisingly frequent and included in the transcript, but not precisely timed. Exact quotations are presented in quotation marks. Respondents frequently reported speech from either their colleagues or patients. Such text will be denoted by single quotation marks (’) within the excerpt. Where I deem context relevant, the turn-taking resulting in the informant's response will be given. Paraphrasing is marked by (paraphrase) following the interview’s date and a lack of quotation marks.

All interviews and texts only available in German were translated personally. I use parentheses and place the German in italics when I feel other translations could’ve been equally valid. Where authors make parenthetical asides, I don’t do this. Square brackets in quotes can denote either missing or garbled words, or a summarisation of material elsewhere in the excerpt. Italics always denote a vocal stress in the interviewee. In those rare instances where I emphasise a phrase, I underline it.

(III) Respondent Pool Summaries

I won’t speak of samples out of some false fealty to statistics. Instead, I refer to a respondent pool peopled by my informants. This terminology reflects the non-random nature of recruitment. Informants were recruited largely through personal referrals (‘snowball sampling’). In the US, I began by sending paper letters as well as emails to some twenty scheduled speakers at the first annual North American
Society for the Study of Personality Disorders (NASSPD) conference. I attended the conference, which overwhelmed me to the point I didn’t introduce myself to people until the final coffee break of the last day. The Boston marathon bombing and subsequent hunt for the suspects placed a damper on the meeting, as many people (notably “the Texas contingent” [overheard in a coffee break]) didn’t attend. I attended the NASSPD meetings in 2013, 2014, and 2015.

The German respondent pool sprang from a well of about twenty German narcissism experts, based on English language publications and books from the local library. Contacts of my supervisor (Dr. Stefan Ecks) at the University of Heidelberg reviewed this list and offered advice. I expanded outward from these cores, interviewing as many of the recommended practitioners as possible. Most respondents in both the US and Germany consented to the use of their name when seeking access.

To insure that my respondent pools would not be entirely experts, I went outside of these networks to find what I called ‘pure’ practitioners. I engaged in such purposive recruitment by contacting several members of the psychoanalytic institute in a mid-sized American city for interviews. Psychoanalysis is less prominent in American psychiatry than in its German counterpart, after all. In Germany, I used a website to find individuals in a mid-size city listing themselves as treating PDs. I contacted seventeen German clinicians, ultimately netting a solitary interview. Another pure practitioner was obtained by sending out a general request to a listserv

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16 ‘Pure’ is a shorthand for non-expert practitioners, with expertise heuristically defined as having one or more publications on pathological narcissism.
devoted to a particular therapy.

Beyond this, some effort was made to match the pools as closely as possible, e.g. interviewing at least one trainee and one young clinician in each context. Matching was not comprehensive: I interviewed a dialectal behavioural therapist in the US, but not in Germany. Ideally, I would’ve done so, and where possible I did interview practitioners who shared a therapeutic approach in both countries to see what contrast this would provide. A further shortcoming of my ‘network-reputational’ approach to gaining access is that I may have missed certain key players in either setting. Seeking pure practitioners was a strategy intended to address potential gaps. On the whole, however, I don’t feel such recruitment severely biased my study. Clinicians did tend to refer to others sharing their therapeutic school, but most did mention outsiders. Particularly in my German respondent pool, saturation was ultimately reached with most referrals being to people whom I'd already interviewed or who had declined or ignored my repeated requests.

The US research took place between April and August, 2013 (five months). My stay in Germany was approximately six months (October 2013 to March 2014, with most interviews being conducted in February and March). Several previously unavailable informants were interviewed in April-July, 2014. Some clarifications were requested after transcription was completed in November 2014. Roughly a year of fieldwork underlies this study. Individual interviews ranged from approximately eighteen minutes to almost two hours in length. Summary ‘statistics’ for each respondent pool
are given in the tables below:

<table>
<thead>
<tr>
<th>Germanophone clinician's identity</th>
<th>Years of experience</th>
<th>Code</th>
<th>Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Researcher</td>
<td>5-10 (research), 5-10 (treatment, treatment &lt; research)</td>
<td>DE-CP-1</td>
<td>CP</td>
</tr>
<tr>
<td>Social worker, family therapist, supervisor</td>
<td>10-20</td>
<td>DE-PP-1</td>
<td>CSW</td>
</tr>
<tr>
<td>Gestalt therapist, specialising in eating disorders</td>
<td>&gt;30</td>
<td>DE-CP-2</td>
<td>CP</td>
</tr>
<tr>
<td>Psychotherapy specialist</td>
<td>20-30</td>
<td>DE-P-1</td>
<td>P</td>
</tr>
<tr>
<td>&quot;My fundamental training is in CBT, and overlaid on that is schema-focused therapy.&quot;</td>
<td>5-10</td>
<td>DE-PP-2</td>
<td>CP (Diplom)</td>
</tr>
<tr>
<td>Specialist in psychiatry and psychotherapy</td>
<td>20-30</td>
<td>DE-P-2</td>
<td>P</td>
</tr>
<tr>
<td>Psychiatrist and psychoanalyst</td>
<td>20-30</td>
<td>CH-P-1</td>
<td>P</td>
</tr>
<tr>
<td>Psychoanalyst, specialising in psychotraumatology</td>
<td>20-30</td>
<td>DE-P-3</td>
<td>P</td>
</tr>
<tr>
<td>Specialist in psychotherapeutic medicine</td>
<td>&gt;30</td>
<td>DE-P-4</td>
<td>P</td>
</tr>
<tr>
<td>Psychiatrist and psychotherapist &quot;with a fundamentally psychoanalytic point of origin, but with additional behavioural [verhaltenstherapeutischen] training.&quot;</td>
<td>20-30</td>
<td>DE-P-5</td>
<td>P</td>
</tr>
<tr>
<td>Psychosomatic medicine and psychotherapy</td>
<td>20-30</td>
<td>DE-P-6</td>
<td>P</td>
</tr>
<tr>
<td>Trained in France, and learned French psychoanalytic theory and technique</td>
<td>&gt;30</td>
<td>DE-P-7</td>
<td>P</td>
</tr>
<tr>
<td>Psychoanalyst</td>
<td>&gt;30</td>
<td>DE-P-8</td>
<td>P</td>
</tr>
<tr>
<td>Clinical psychologist and cognitive-behavioural-therapist</td>
<td>5-10</td>
<td>DE-CP-3</td>
<td>CP</td>
</tr>
<tr>
<td>&quot;Psychoanalytic psychotherapist and psychiatrist&quot;</td>
<td>10-20</td>
<td>CH-P-2</td>
<td>P</td>
</tr>
<tr>
<td>Specialist in trauma therapy and the treatment of personality disorders</td>
<td>20-30</td>
<td>DE-P-9</td>
<td>P</td>
</tr>
<tr>
<td>Clinically concentrated on the treatment of severe PDs. Coach, consultant, and supervisor.</td>
<td>&gt;30</td>
<td>DE-CP-4</td>
<td>CP</td>
</tr>
<tr>
<td>&quot;Classical Freudian psychoanalyst with an affinity to Kohutian self-psychology&quot;</td>
<td>&gt;30</td>
<td>DE-CP-5</td>
<td>CP</td>
</tr>
</tbody>
</table>

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17 In the tables, P stands for psychiatrist, CP for clinical psychologist, (L)CSW for (licensed) clinical social worker, and SPP for social-personality psychologist.
<table>
<thead>
<tr>
<th>Position</th>
<th>Years</th>
<th>Code</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy of severe psychological disorders [psychischer Störungen], psychotherapist and psychoanalyst.</td>
<td>&gt;30</td>
<td>DE-P-10</td>
<td>P</td>
</tr>
<tr>
<td>Psychosomatic ailments and personality disorders. &quot;On the one hand, my orientation is relatively strongly behavioural [verhaltenstherapeutisch], but it's also humanistic [gesprächstherapeutisch] and draws heavily on Greenberg's perspective, &quot;Working with emotions in psychotherapy&quot;.&quot;</td>
<td>&gt;30</td>
<td>DE-CP-6</td>
<td>CP</td>
</tr>
<tr>
<td>Specialist in psychiatry and psychotherapy, forensic psychiatry, and addictions</td>
<td>&gt;30</td>
<td>A-P-1</td>
<td>P</td>
</tr>
<tr>
<td>Head of research and quality assurance, psychological psychotherapist and CBT supervisor</td>
<td>20-30</td>
<td>DE-CP-7</td>
<td>CP</td>
</tr>
<tr>
<td>Psychiatrist specialising in psychotherapy and psychosomatics, psychoanalyst</td>
<td>20-30</td>
<td>A-P-2</td>
<td>P</td>
</tr>
<tr>
<td>Psychoanalyst, doctor, psychiatrist</td>
<td>&gt;30</td>
<td>DE-P-11</td>
<td>P</td>
</tr>
<tr>
<td>Psychoanalyst</td>
<td>&gt;30</td>
<td>DE-P-12</td>
<td>P</td>
</tr>
<tr>
<td>North American clinician's identity</td>
<td>Years of experience</td>
<td>Code</td>
<td>Field</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------------</td>
<td>--------</td>
<td>----------------</td>
</tr>
<tr>
<td>CP</td>
<td>20-30</td>
<td>US-CP-1</td>
<td>CP</td>
</tr>
<tr>
<td>CP</td>
<td>5-10</td>
<td>US-CP-2</td>
<td>CP</td>
</tr>
<tr>
<td>CBT therapist</td>
<td>&gt;30</td>
<td>US-CP-3</td>
<td>CP</td>
</tr>
<tr>
<td>CP, &quot;and in this regard I consider myself (in no particular order) a researcher, clinician, and teacher.&quot;</td>
<td>10-20</td>
<td>US-CP-4</td>
<td>CP</td>
</tr>
<tr>
<td>Relational psychodynamic</td>
<td>10-20</td>
<td>CA-CSW-1</td>
<td>CSW / Psychotherapist</td>
</tr>
<tr>
<td>Psychoanalyst</td>
<td>&gt;30</td>
<td>US-PP-1</td>
<td>CP</td>
</tr>
<tr>
<td>Psychoanalyst</td>
<td>&gt;30</td>
<td>US-CP-5</td>
<td>CP</td>
</tr>
<tr>
<td>&quot;clinical professor of psychiatry... I devote my professional time to treating patients, which I still see as the core; to teaching and supervising...; and to writing...; and to being a part of a research team, but I don’t describe myself as a researcher. &quot;</td>
<td>&gt;30</td>
<td>US-P-1</td>
<td>P</td>
</tr>
<tr>
<td>P</td>
<td>&gt;30</td>
<td>CA-P-1</td>
<td>P</td>
</tr>
<tr>
<td>CP</td>
<td>10-20</td>
<td>US-CP-6</td>
<td>CP</td>
</tr>
<tr>
<td>&quot;Director of Clinical Training and my research is in personality disorder&quot;</td>
<td>&gt;30</td>
<td>US-CP-7</td>
<td>CP</td>
</tr>
<tr>
<td>P</td>
<td>&gt;30</td>
<td>US-P-2</td>
<td>P</td>
</tr>
<tr>
<td>Psychoanalyst</td>
<td>--</td>
<td>US-PP-2</td>
<td>LCSW</td>
</tr>
<tr>
<td>Interpersonal psychotherapist</td>
<td>&gt;30</td>
<td>US-CP-8</td>
<td>CP</td>
</tr>
<tr>
<td>&quot;[Post-]Graduate student at a large academic university, psychodynamically oriented primarily.&quot;</td>
<td>&lt;5</td>
<td>US-CP-9</td>
<td>CP</td>
</tr>
<tr>
<td>Psychodynamic psychiatrist</td>
<td>&gt;30</td>
<td>US-P-3</td>
<td>P</td>
</tr>
<tr>
<td>DBT therapist</td>
<td>5-10</td>
<td>US-CP-10</td>
<td>CP</td>
</tr>
<tr>
<td>&quot;I practice from more of a psychoanalytic or psychodynamic framework, but I'm also interested in the integration of clinical work and empirical work as well, and so how the two mutually inform each other.&quot;</td>
<td>10-20</td>
<td>US-CP-11</td>
<td>CP</td>
</tr>
<tr>
<td>Psychoanalyst</td>
<td>--</td>
<td>US-PP-3</td>
<td>CP</td>
</tr>
<tr>
<td>Head of prestigious organisation</td>
<td>20-30</td>
<td>US-LCSW-1</td>
<td>LCSW</td>
</tr>
</tbody>
</table>
Banded years of experience are given at the time of interview to further protect anonymity, and to simplify comparisons between the two respondent pools. Some interviewees were only later asked how they self-identify and didn’t respond to repeated inquiries. In these cases, I have ascribed an identity as best I could, usually their profession. Though >30 is the highest ranking, several informants had considerably more experience than 30 years. Additionally, the North American “director of clinical training” is an assessment specialist and a highly influential practitioner, though not a clinician.

My respondent pool’s composition calls for two crucial caveats. I interviewed no therapists who described themselves as humanistic, though two Germans (one Gestalt therapist, the other systemic) arguably hang their hats in that house. Certain psychotherapies I investigate (notably clarification-oriented and dialectal behavioural therapy) are influenced by humanistic approaches. Given the prominence of this theoretical tradition in psychotherapy, I cannot confidently claim humanistic understandings of and treatments for narcissistic personality resemble their psychodynamic and cognitive-behavioural cousins. Secondly, psychiatrists giving psychotherapy may well be different in kind than their physiology-focused siblings.

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18 In a 2004 survey of Australian counsellors and psychotherapists, 12% were primarily humanistic/existential/experiential in their primary theoretical orientation (Schofield 2008:8). A Canadian survey of clinical psychologists yielded 5.3% with person-centred and 4.6% of humanistic orientation (Warner 1991:527). In the UK, a majority (57.34%) of those surveyed used humanistic and integrative psychotherapy as a theoretical base (Aldridge & Pollard 2015:19).
Psychoanalytic psychiatrists, interviewed by Smith (2014), are argued to diagnose more medically than psychodynamically. Further research is needed on both humanistic approaches to narcissism and what differences exist between psychiatrist-psychotherapists and ‘pure’ psychiatrists.

Cases arose where the easiest means of summarising a great deal of data was to construct a summary table. When building these, I tried to capture as much of the individual flavour of the respondent’s words while binding them into (a minimum of) meaningful categories. Judgment was required here, as it is in all science. Is “[Größenselbst narcissists] want to prevent one from getting behind their façade, their mask” (DE-P-4, 4.02.2014) a case of narcissistic retreat, as well as being emotionally distant, intellectualising, or rationalising? In such instances, I erred on the conservative side and didn’t infer. I felt that this was crucial given the intimate connection between theory and language. Strictly speaking, one cannot compare raw counts, but my goal with these tables was impressionistic, not absolute precision.

(IV) What about National Contexts?

There is an official split between the US and the rest of the world, between DSM and ICD. While this is often not recognised in practice, there are sound conceptual reasons to consider national contexts. Fourcade (2009) suggests “the context of economic knowledge production also directly structures the substantive content of economics, encouraging the use of certain research orientations, technical tools, styles of reasoning, and theoretical schemes and preventing others from being seen as relevant or appropriate” (17; cf. MacKenzie 1981). The examples of psychosomatics
and diagnostic interviews suggest that the same principle operates in psychiatry. In
the Germanophone world, there is a psychosomatic specialisation, the Facharzt für
Psychosomatik und Psychotherapie, as well as a preponderance of psychosomatic
clinics. The US and Canada, to my knowledge, have no such institutions. For the
most part, the diagnostic interviews used in both settings were the same – except that
the German versions have been translated and often revalidated. We can find
however, distinctly German instruments, such as Denke and Hilgenstock’s
Narzissmusinventar (2008), and Grawe and Kaspar’s “interview for the assessment
of motivational schemata” (DE-CP-3, 22.01.2014). Furthermore, “every intellectual
field is stratified according to the nature of the competition that takes place within it”
(Fourcade 2009:23-24). This competition is to an extent international, but “this
global field is just as much a historical achievement as the national fields” (ibid:256).
While some intellectuals had circulated through different Germanophone countries,
the bulk stayed in one nation. I take this to mean that, although less between
countries sharing a language, national context nevertheless remains relevant.

A central distinction which this study couldn’t examine is the economic and
especially legal standing of psychotherapy and the restricted use of specific
professional titles. Under the German Gesetz über die Berufe des Psychologischen
Psychotherapeuten und des Kinder- und Jugendlichenpsychotherapeuten19 (1999),
the titles of “psychological psychotherapist” and “child and adolescent

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19 Full-text of all laws are available online:
(1) German Psychotherapeutengesetz: http://www.gesetze-im-internet.de/psychthg/BJNR131110998.html,
(2) German Heilpraktikergesetz, http://www.gesetze-im-internet.de/heidprg/BJNR002510939.html,
(3) Austrian Psychotherapiegesetz, http://www.ris.bka.gv.at/GeltendeFassung.wxeAbfrage=Bundesnormen&Gesetzesnummer=10010620, AND
psychotherapist” are legally protected and as such require a specific course of training to be claimed. Of special relevance here is § 1.3 (though see also §11 on “Scientific Acknowledgement”), which begins, “The practise of psychotherapy as defined by this law is every scientifically acknowledged psychotherapeutic method undertaken to assess, heal, or ease disorders which approximate illness (Störungen mit Krankheitswert), where psychotherapy is indicated.”

Prior to the Psychotherapeutengesetz, psychologists could not obtain money directly from the state insurance (Krankenkassen). A Delegation from a doctor was necessary for a psychologist to treat patients and receive these funds. This law, then, served to grant the psychologists independence from the doctors and create a separate sphere for them. Psychotherapy as a curative method (Heilmethode) then became the legally protected preserve of psychologists and physicians equally. Exceptions do exist, notably individuals who conduct psychotherapy as “Heilpraktiker für Psychotherapie” under the auspices of the Gesetz über die berufsmäßige Ausübung der Heilkunde ohne Bestallung (“Law for the professional practise of medicine without a license,” orig. 1939). Psychoanalysts don’t enjoy any legal protection of their title. As a psychotherapeutic method, however, the practice is mostly restricted to those with the legal right to apply this intervention (doctors, psychologists). Heilpraktiker can train as lay analysts, but cannot obtain payment from the governmental insurance. As such, there are extremely few lay analysts for both legal and economic reasons20.

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20 These paragraphs owe much to Dr. Heribert Blaß.
Similar legislation exists in Austria (*Bundesgesetz vom 7. Juni 1990 über die Ausübung der Psychotherapie*), which references “scientific-psychotherapeutic methods” (§1.1). In Switzerland, the recently-passed (2013) *Bundesgesetz über die Psychologieberufe* (PsyG) offers a similar legal definition for clinical psychologist (*Psychologe, Psychologin*), stressing that training must leave the clinician competent to “apply current scientific knowledge, methods, and techniques” (Ch. 3, Paragraph 1, Article 5.2a). These laws serve as a reminder of the state as “a symbolic institution with a power of certification, consecration, legitimate classification, and categorisation” (Fourcade 2009:249). We see also many boundaries involved in psychotherapeutic work, a theme this study treats in depth.

(V) Talking Terminology

A study of a contested category is inevitably entombed in some linguistic limbo. Explanatory and emancipatory indulgences are hereby offered, only at the expense of effort and attention.

The psychotherapies I studied offer an opaque alphabet soup to the uninitiated. To be economical, I’ll generally refer to the therapies by their acronyms and so introduce them here. Only one three-letter therapy is uniquely German: clarification oriented psychotherapy (COP; e.g. Sachse, Sachse, & Fasbender 2011). Cognitive-behavioural therapy, or CBT (Beck, Davis, & Freeman 2015), is perhaps the best-known. A treatment for borderline PD, which grew out of CBT, is dialectical behaviour therapy (DBT; Linehan 1993a; 1993b). Schema therapy (ST; Young, Klosko, & Weishaar 2003) blends elements of CBT with theories and interventions
from other theoretical orientations. Transference-focused psychotherapy (TFP; Yeomans, Clarkin, & Kernberg 2015) is a manualisation of Kernberg’s (e.g. 1984) clinical wisdom. Other treatments under consideration don’t have such pithy epithets and must be properly named.

Unless otherwise noted, “psychiatry” or “psychiatric” is used as an [ecumenical term for the various mental health professions and sciences I researched. “Normal” or “normative” are used in the natives’ (statistical) sense. An analytical distinction must be made between natural (biological or statistical) and social norms, which most sociologists all too contentedly conflate. The normal distributions of temperaments across individuals, and a normative life course (birth, stages of brain and relational development, degeneration, death) obdurately exist no matter what objects we insert in our ears. A massive amount of variation exists, but these trends can nonetheless be teased out. Social (i.e. moral) valuations will be explicitly marked as ethical appraisals.

What I’ve heretofore called theory travelled under an assortment of aliases amongst my informants. The most common among these were model(s), concept(s) or conceptualisation, and in the Germanophone context, Ansatz. Other terms included Art, Verfahren, treatment concept, school(s), Therapieform, method, orientation, approach, perspective, technique, strategies, and point of view (Betrachtungsweise). Few informants referred explicitly to theory. I’ll hold mainly to the native terms, model, concept, conceptualisation, and Ansatz, though other psychotherapeutic pseudonyms or even theory may unexpectedly emerge.
I won’t follow anthropological convention (Eisenberg 1977, Kleinman 1980) and distinguish between disease (as the biologic or medical entity) and illness (as the individual or social experience). For a clinician, these always fuse – particularly in psychiatry. My informants were always concerned with the individual, though some psychoanalysts tended to stress this more. Had I dealt with patients, this distinction would perhaps be meaningful. There would be, for instance, the question of whether the disease remains cooped up in the consulting room and the illness outside. When dealing with practitioners, distinguishing disease from illness gives little – if any – analytic edge. My second point is stylistic: it becomes a bore to reiterate one word over and over.

Finally, how will I personally refer to so-called service users? Circumlocution could be defined by referring to them thusly. Substituting consumers for users only sinks us deeper into sin. Client is roughly on par with consumer in its capitalistic presumptions. Goffman's (1961a) “mental patients” are in-patients of psychiatric units only. To call them mentally ill might be taken as ‘oppressive,’ or ‘degrading.’ I choose the brevity and accuracy of calling such individuals patients. Such a claim can be made because they are, as a rule, in treatment. Respondents did refer to individuals receiving coaching or counselling, or prefer another expression (usually client) for those in psychotherapy. To use the word patient in these instances would be unethical and distort the informant’s intended meaning (see Ferrara 1994:18-19). I therefore retain the respondent’s representations in such instances.
A variety of boundaries and issues involving the words “narcissism” or “narcissistic” will crop up. NPD will be used solely for the official diagnosis. Distinctions between normal (or healthy) and pathological narcissism, or narcissistic personality style versus the PD, are described in the respondents’ own words. I may suggest commonalities across therapeutic camps, but by no means do I dictate these definitions or decree where the dividing line lies.
Chapter 4: Skin-Deep Differences: Defining NPD

In this chapter, I introduce the central theme of this thesis: the complex relationship between the various psychotherapies used to treat NPD. I do so by covering the various types of narcissism and related phenomena my informants described to me. My aim here isn’t textbook definition, but rather to show the working models these practitioners used in research and/or treatment. To do so properly, first some sensitising concepts must be introduced. The behaviour-insight divide is introduced, with the therapies used for BPD shown as falling along a behaviour-insight spectrum. Many of the same therapies are used for NPD, thus importing the continuum is not problematic. A rough genealogy of the relevant psychotherapies is given to provide the reader context for the coming chapters.

Having done this, our attention turns to how my informants and the official classificatory schemes define pathological narcissism. A range of related phenomena, such as narcissistic rage, are also discussed. We close comparing the numbers of patients my respondents estimate they’ve treated and lists of works they consider important. The superficial diversity amongst my informants poses the problem I hope to answer: how can field seem so divided and yet be almost unified in practice? We turn now to questions of syn- and diachronic relationships between the miscellaneous psychotherapies.
The Behaviour-Insight Spectrum and Psychotherapeutic Genealogy

Michael Stone’s (2006) work on the limits of treatability in PDs points us toward a defining distinction made by psychotherapists. Essentially two points of (psychotherapeutic) entry to psychiatric illness are seen: insight and behaviour.

![Diagram of Behaviour and Insight](image)

**Figure 4.1: Points of entry and mechanisms of change in psychotherapy**

Insight-oriented approaches (also called exploratory or expressive psychotherapies) are typically psychodynamic, with some exceptions (e.g. Carl Rogers’ person-centred therapy). Behavioural techniques tend to be more directive and oriented towards observable phenomena. The central assumption of both is that entering at and adjusting one pole will cause the other to be altered.

Psychotherapies can also be conceptualised as occurring along a spectrum, as the following illustration suggests:
Figure 4.2: Psychotherapeutic spectrum of BPD treatments, after Gunderson (2015)

Not all of these treatments were utilised by my respondents. While there were references to usage of MBT for NPD, TFP was clearly the dominant psychodynamic approach amongst my respondents. Good psychiatric management is a generalist approach to handling BPD and is very closely keyed to that illness. As such, these treatments aren’t addressed. Gunderson’s model, however, guides our understanding of the interrelations in this alphabet soup. My chapters will utilise this behaviour-insight axis to facilitate comparison. In conceptualising the relationships between therapy schools, one must also consider chronological and genealogical aspects:
The above illustration offers the uninitiated a simplified and stylised introduction to
the diachronic relationship of various therapeutic schools. It must be noted that there
is considerable cross-pollination (e.g. the influence of object relations on ST) and
certain traditions (e.g. interpersonal psychoanalysis, which has influenced current
interpersonal therapies) which have been pruned or ignored (see Davies 2009:35-36
on the web-like and hierarchical aspects of psychotherapeutic “kinship” charts).
Biopsychiatry is perhaps the most notable absence. For many methods,
psychopharmaceuticals are an acceptable adjunct. The alliance between talk and
tablet will be explored as far as the data (interview or manuals) allow.

Additionally, virtually all these methods have adherents in the present day. Dates
aren’t given, though as we move from top to bottom we go backwards in time.
Cognitive therapy was cotemporaneous with, but did not emerge simultaneous to the
post-Freudian schools of psychoanalysis. Finally, while cognitive therapy’s children
are portrayed as independent, this depiction is only a convenience, with present-day
psychodynamic approaches (e.g. Kernbergian, Kleinian, Kohutian21) sketched similarly. The complex relationship between these therapies will be the subject of this thesis, beginning with the definitions sketched by the practitioners I spoke with.

(II) “Now I'd guess that you get as many definitions of narcissism as people you ask”, or: Never mind a name, what stands behind it?

One psychiatrist (DE-P-3, 13.01.2014) summarised the overarching problem of this chapter, and to an extent the entire thesis, with his estimation of how many different definitions of narcissism I would hear. One of my most difficult analytic tasks has been to attempt to at best uncover an underlying uniformity, or at worst infer and thus inject artificial order. Several informants (e.g. CH-P-1, 22.01.2014) called me on implicitly drawing upon this theoretical uncertainty in asking how they understood narcissism. One psychiatrist (CA-P-1) bluntly began, [I]t’s not a personal thing” (21.08.2013). I gave a nervous titter before he went on, explaining that he uses the DSM and that “we have to agree on these definitions.”

Several respondents referenced paradoxical aspects of narcissism. One practitioner, for instance, pointed up its “lay popularity, and yet clinically… it’s not really talked about often enough” (CA-CSW-1, 6.09.2013). A second paradox “is that in

21 Melanie Klein (1882-1960) “argued that young infants were unable to integrate their powerful conflicting feelings about their mothers’ breasts, that they felt both loving dependence and rageful frustration, and that in consequence they swung between perceiving a good breast and perceiving a bad one” (Luhrmann 2000:254). Heinz Kohut (1913-1981), like his adversary Otto Kernberg (1928-), was born in Vienna. “To put it crudely, in the Freudian model a therapist’s job was to interpret a patient’s unconscious conflicts; in Kohut’s ‘self-psychology’ a therapist’s job was to repair a patient’s emotional deficits through the relationship in therapy” (Luhrmann 2000:110). Kernberg is influenced by Klein, and his “work teaches that hostility – not loneliness, not love – is a driving emotion behind human experience, that idealization can be a mask for persecutory anger and affection a subterfuge for sadomasochism” (Luhrmann 2000:146).
psychodynamics, it’s talked about a lot… [b]ut, on the other hand, empirically, we know very little about pathological narcissism.” Another psychodynamic respondent also underscored a pair of paradoxes:

“… principally, my opinion is that narcissism is a paradox insofar as firstly it has completely different degrees of severity (Auszprägungsgrade) from the lighter forms – shall we say – up to the heaviest, and narcissism looks like overinflated self-worth but in principle it’s the expression of a difficulty (Problematik) in the domain of self-worth.” (CH-P-1, 22.01.2014)

Another informant (US-CP-4) saw a multitude of definitions made into narcissistic foie gras: “I think the answer to is that we have to have more specific terms for what we mean” (21.04.2013). In our second interview, he connected this definitional dilemma with measurement:

“There hasn't been a way to do it, because the social psychologists think of narcissism as self-esteem, more or less, and the clinical psychologists and psychiatrists think of it as being a grandiose jerk, and neither one of those really are all that consistent with the clinic literature on the construct. So that to me, has been the main problem, which is why [Aaron Pincus’] stuff is so important, because it provides some initial evidence-based foundation to study the stuff that clinicians have been talking about all along.” (3.05.2013)

The problem is fundamentally sociological: measures are to a degree inscribed with theoretical meaning, which then renders comparison between many instances of ‘the same’ object difficult, if not impossible. Even the DSM’s ‘atheoretical’ understanding represents in some sense a particular carving of narcissism where it “got bastardised into this descriptive set of features involving being a grandiose jerk” (US-CP-4, 3.05.2013; see e.g. CH-P-1, US-CPs 1 and 9 for similar stances).
We are led here into a mine, where all shafts have aimed to extract some aspect or alloy of narcissism. Related to pathological narcissism are (at least) four native categories: (1) cultural narcissism, (2) normal (or healthy) narcissism, (3) the question of subtypes, or how grandiosity and vulnerability relate in pathological narcissism, and finally, (4) the related phenomena of narcissistic injury and narcissistic rage. We will travel through these in order, and close with (5) the official versions of NPD. Even in this rough census of different understandings of pathological narcissism, we will see that similarities predominate.

(II.1) Cultural narcissism

Societal narcissism, interestingly, went almost unmentioned by my informants. The clearest exception was a German psychiatrist (DE-P-3) who, in describing narcissism, said it was a “feature (Merkmal) of our time” (13.01.2014). When I asked him to elaborate, he said:

“You can find purity ideals (Reinheitsideale) everywhere. People must be young, people must be beautiful, people aren’t allowed to be hairy, they aren’t allowed to be too fat, they must be flawless and clean. Conflicts in relationships aren’t allowed to come up, we don’t have any debating culture (Streitkultur) anymore, ‘political correctness’ is encouraged everywhere. You aren’t allowed awkward (quere) or unusual (schräge) opinions (Ansichten), and you don’t like the stranger on the street either. So societally, interactionally, and intrapsychically.” (13.01.2014)

Other Germanophones (e.g. CH-P-1, DE-CP-7) briefly referred to surveys of college students and doubted whether these were really measuring narcissism (see Ch. 8). Three informants (A-P-1, DE-P-2 DE-CP-2) briefly mentioned that they felt the prevalence of narcissism was on the rise and represented an important social
problem. One American used the example of Argentina (US-CP-3, 2.08.2013) to suggest that narcissism could become a national style, just as OCD (his second example) could cheekily be cast as the German national style. An American (US-CP-6) suggested that “low rates of diagnosis as an artefact of” clinicians’ unwillingness or inability to tactfully convey an NPD diagnosis (7.06.2013). While he didn’t mention nation or culture explicitly, there are empirical reasons (cf. McDonald-Scott et al. 1992 on diagnostic disclosure in Japan and North America) to believe that these can distort the prevalence of NPD.

\textit{(II.2) Normal narcissism}

My respondents mainly focused on individuals, rather than how a ‘culture of narcissism.’ One ST clinician (US-LCSW-1), however, expressed some insight when contrasting “healthy adult mode” and “healthy adult narcissism”:

“…some of my friends, and even in [Germany] and in the UK will say, ‘You know, there’s no healthy narcissism. It’s just not right to boast and brag.’ And we laugh about it (CFD laughs), we make jokes about this all the time because I think there are discrepancies in culture about what’s healthy and not healthy about narcissism.” (16.09.2013)

While she initially refers to it as “cultural bias,” we find an experienced clinician’s comprehension of what Horwitz (2002, following Cullen 1983) calls the “structuring” of mental illness.

Normal narcissism, as we would expect from Horwitz (2002), takes on a rather different cast depending on where we are in the world. If different societies channel distress into varied expressions, then it stands to reason that normality would also take on multiple guises. Understandings of healthy or normal narcissism would then
vary not just by theoretical approach (as I argue), but also by cultural context. The respondent above (US-LCSW-1) suggests that “healthy adult narcissism” can look much like narcissism, but is different in its aim: “So the motivating driver, it looks like it’s all about them and in many ways it is all about their actions, but it’s motivated by this genuine desire to create a greater good for someone else or for others” (16.09.2013). A “graduate student at a large state university, psychodynamically oriented primarily” (US-CP-9) came to an astoundingly similar conclusion: “But eventually this aspect of adaptive narcissism is when you work through all those negative aspects and you use qualities like ambition and charisma to get you what you want and to satisfy others as well” (6.06.2013). Entitlement, rather than pro-social or narcissistic motivation, was what differentiated normal and pathological narcissism for another respondent (CA-P-1, 21.08.2013).

Several psychodynamic practitioners referred to normal narcissism in rather broad terms. For instance, when I asked a "classical Freudian psychoanalyst with an affinity to Kohutian self-psychology" how he recognised narcissism, he answered immediately and without any doubt: “Always. (CFD laughs.) Every patient. Narcissism is another word for wanting to be alive (Lebendigseinwollen). I want to sustain my self” (DE-CP-5, 4.03.2014). Many Germanophones cited Heinz Hartmann’s definition of narcissism as “the libidinal cathexis of the ego (die libidinöse Besetzung des Selbst)” (e.g. DE-P-12, 17.02.2014). Curious here was one clinician (DE-P-5) who described normal narcissism not as something basic, but as something which could become pathological. After listing businessmen and journalists, he went on to cite universities, where many “… convert the primary
affect of latent or manifest inferiority into a specific interest in inquiry
(Fragestellung) that can gain something like a self-worth regulatory character in practice” (28.02.2014).

Others stood out in taking more of a developmental approach to normal narcissism. One more integrative clinician (US-CP-4) postulated a “sort of normative developmental trajectory,” where pathological narcissism represents “a lag in that process, where, relative to other people your age, you have more self-investment than, than you might otherwise have” (21.04.2013). He had a curious affinity with a French-trained German analyst (DE-P-7) who described “a maturation (Reifung) in three vectors” (interpersonal, intrapsychic, and “the domain of speech”), where “[d]epending on how far the maturation has progressed in each of these three domains, the person is more or less stable” (13.02.2014). One Austrian (A-P-1) gave a medical metaphor, indicating, “It’s the dose alone that makes it poisonous, and it’s also that way in the domain of narcissism” (20.02.2014). He suggested that one’s development could lead to a normal, pathological, or “malignant (bösertiger)” narcissism.

Many Germans followed Ritter and Lammers (2007) in saying that narcissism could be a variable personality trait or a PD (e.g. DE-CP-1, DE-CP-3, DE-P-6, and DE-PP-1). The ‘pure practitioner’ (11.03.2014) was peculiar in that he endorsed not only inter- but also intra-person variability in narcissistic traits or behaviours. Across my informants, it can be said that “the dimensional issue's resolved” (US-CP-2, 10.05.2013). This recognition is, in this respondent’s telling, “just not accepted” in
the broader field where categorialists and dimensionalists\textsuperscript{22} butt heads. What varies across and even within the theoretical schools I studied is how we carve up the continuum: the thorny issue of normality versus pathology here stomps into sight.

One surprising finding I can report now is that there was agreement between a sceptic and those seen as having low diagnostic thresholds. For instance, take these two quotes: (a) “I believe [and] respectively am convinced that [NPD] is extremely rare, on the basis of the empirical data”, and (b) “I think here you have to differentiate a lot, because they [i.e. genuine NPD cases] really crop up relatively rarely.” Who practices Gestalt therapy (DE-CP-2, 12.02.2014) and who CBT (DE-CP-7, 21.02.2014)? If one guessed that (a) is CBT and (b) Gestalt, one was correct.


Dimensionality was often utilised as a tool in understanding normal and pathological narcissism, as well as their relationship. One clinician (DE-CP-1) suggested that in the case of normal narcissism, “various constructs are mixed together” (5.03.2014). She said that in the NPI there were “also items that go more in a pathological

\textsuperscript{22} To oversimplify, the issue is whether discrete, categorical diagnoses are present or absent. Dimensionalists believe that describing PDs as being on a continuum with normal personality is more accurate both clinically and scientifically.
direction,” which isn’t “a high sense of self-worth” which is “what is typically meant by normal narcissism”. There was some disagreement about whether normal and pathological narcissism used the same self-regulatory mechanisms (CA-CSW-1), or different strategies with different motivations (US-CP-9). One clinician (US-CP-2) listed several means for determining whether narcissism was pathological or not:

“So if it's the kind of thing where if I don't get those needs met I become dysregulated and emotionally, interpersonally et cetera, then it becomes pathological. Or if it mixes with my own inability to sort of curtail those sorts of needs in particular situations, then it can become pathological. So I guess the sense is that it's the basic aspect of [the] human condition to have these needs, but then how it's managed or how sort of rigidly or extremely one pursues these needs, that's when it tends to go awry.” (10.05.2013)

Overall, I would say that many or most of my informants could agree that, “[I]t doesn’t become a disorder until it’s maladaptive” (US-CP-3, 2.08.2013). The same practitioner implied that the criteria for NPD had to be contextualised. He posed a thought experiment where one would test for NPD in “twenty people pull[ed] off the street [at noon in a city’s downtown]”, and indicated that “a number of them probably would meet criteria.” These people would include “presidents of companies,” and thus he concluded, “It's when they are retired, and no longer get their narcissistic style met, that it becomes a disorder, they become demanding, they become obnoxious.” One clinician (DE-CP-2) saw narcissism as existing on a continuum, and that it only became disordered when “a permanent hunger arises for consideration (Beachtung), for attention (Aufmerksamkeit)” (8.01.2014).

A research psychologist (US-SPP-1) described it in terms of “ingredients of narcissism,” which included “some sort of extraversion-insurgency, and then some sort of low agreeableness” which “might be grandiosity [or] lack of empathy”
(26.05.2014). He added that you had a dynamic, self-regulatory element, “all those basic dynamics that keep your self inflated, or inflate it further.” His closing was perhaps the most interesting: the model he presented “looks a lot like a psychodynamic model, except in psychodynamic you might invoke some sort of unconscious motivations as well” (26.05.2014).

In other cases, it wasn’t simply that the personality style could flow into the disorder, but that what were sometimes regarded as independent illnesses (e.g. avoidant PD and malignant narcissism) existed on a spectrum. Such views were typically held by TFP practitioners. Doering (2012:64) offers the clearest example of this. For a younger CBT clinician (DE-CP-1, 5.03.2014), “there could be something to it, whereby I’m always glad to argue using empirical data.” A practitioner in a similar position (DE-CP-3) used this potentiality to demonstrate that categorical splits were “too speculative, or respectively too arbitrary (Willkürlich)” (22.01.2014). This description of the cut-offs as arbitrary was common, though respondents varied in how displeased they were with using the DSM as a temporary fix. While national context could contour how normality was understood, by and large conceptual models helped practitioners bound the normal and the pathological. The Psychodynamic Diagnostic Manual (PDM 2006, henceforth PDM) introduces another classificatory scheme, and another dubious distinction: Are there subtypes of pathological narcissism?

(II.3) Subtypes and the Psychodynamic Diagnostic Manual

Interlaced with issues of dimensionality and the pathology threshold is the concept of
disease presentation, and thus whether subtypes of narcissism exist. The PDM summarises NPD as follows (39-40):

“**Contributing constitutional-maturational patterns:** No clear data

**Central tension/preoccupation:** Inflation/deflation of self-esteem

**Central affects:** Shame, contempt, envy

**Characteristic pathogenic belief about others:** Others enjoy riches, beauty, power, and fame; the more I have of those, the better I will feel

**Central ways of defending:** Idealization, devaluation

**Subtypes:**

**P104.1 Arrogant/Entitled**

… Behaves with overt sense of entitlement, devalues most other people, strikes observers as vain and manipulative or charismatic and commanding.

**P104.2 Depressed/Depleted**

… Behaves ingratiatingly, seeks people to idealize, is easily wounded, and feels chronic envy of others seen as in a superior position.”

Beyond the obvious division into two subtypes, several features ought to be noticed. The inclusion of specific code numbers emulates the DSM or ICD: in a sense, then, the PDM has been designed to look like a scientific manual. Some features are obviously analytic (e.g. defence mechanisms), but most others are compatible with other theoretical traditions. “**Characteristic pathogenic belief about others**” fits

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23 I’ve excised references to the psychoanalytic literature.
particularly well with CBT. Beck and colleagues (2001) use dysfunctional beliefs to
discriminate PDs, for instance “the PBQ Narcissistic items ‘I am a very special
person’ and ‘Other people should recognize how special I am’” (1217).

This subtype view was espoused by a German clinician (DE-P-4) who used
psychoanalysis (amongst other methods), but saw himself primarily as a specialist
for psychotherapeutic medicine. I asked him whether impaired empathy
Empathiemangel was associated with both Größenselbst (grandiose self) and
Größenklein (roughly, small grandiosity). He began by pointing out the similarity, as
both “have little empathy for others,” before elaborating:
“In the Größenselbst because one also sets oneself centre stage as ‘I’m the biggest,
I’m the most beautiful, the most important,’ and then also in the Größenklein as ‘I’m
always the worst, I’m the dumbest, I’m in last place.’” (4.02.2014). When asked
directly as to how he saw the connection between overt (offener) and covert
(verdeckter) narcissism and Größenselbst/Größenklein, he opened his remarks with
“If one were to compare these…” (4.02.2014), before making the overt-grandiose
and covert-vulnerable connection. I perplexedly take this to mean that he does not
necessarily see these as interchangeable terms, though they seem to be highly related
concepts.

One DSM-oriented TFP practitioner pointed to “a kind of negative narcissism (minus
Narzissmus)” (CH-P-2) that he encountered in people who wanted to be “the most
miserable, most terrible patients” (20.02.2014). I am unsure if these men are
discussing the same patient population, though based on the German’s comment
(“One also sets oneself centre stage, but more in a negative variant, with all negative characteristics”, 4.02.2014), I am inclined to believe so. A DBT clinician feeling “that research really suggests there’s kind of two strains of narcissism” (US-CP-10, 15.08.2013) is also intriguing, as again we have an intertheoretical marriage. An American analyst (US-PP-1, 23.05.2013) listed the PDM subtypes, though he added the word passive in between depressed and depleted.

Others see grandiosity and vulnerability as two facets or presentations of the same underlying pathology (e.g. CA-CSW-1, DE-CP-5, US-CP-6, US-P-3). Pincus and Lukowitsky (2010:431, Fig. 2), for instance, propose a hierarchical model of pathological narcissism where both grandiosity and vulnerability can have a covert or an overt expression.

A TFP practitioner (A-P-2) describing “narcissistic disorder in its broadest sense, a disturbance of self-esteem regulation and stability” (22.04.2014) spoke of vulnerable and grandiose Ausprägungen (expressions). One integrative clinician (DE-P-9) combined this notion of two presentations with an aetiology of childhood trauma24 (12.03.2014). He elaborated when asked if narcissists have impaired empathy:

“So it’s right and it’s not. It’s right when one says there are people who aren’t so good at self-integration, have little self-empathy, also can’t identify with others’ needs very well because they’re not used to it, haven’t learned in childhood, here maybe also neglect to it, have too little experience of encouragement. But I don’t think a lack of empathy constitutes the fundamental problem, rather that here there’s a habit not to sympathise with others or oneself too well, but that the potential is already in them.”

He referred to research on psychopaths to demonstrate how empathy could be switched on and off, utilising the example of surgeons to drive this point home.

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24 DE-P-10 (21.03.2014) mentioned trauma as a potential pathway to narcissism.
Despite agreeing that grandiosity and vulnerability were both essential facets of pathological narcissism, COP was unique in its almost sociological classification. Sachse, Sachse, and Fasbender (2011) propose three types of narcissists: (1) successful (erfolgreiche), (2) crashed (gescheiterte), and (3) success-less (erfolgslose) narcissists. Each definition begins “These are people with a narcissistic accentuation (Ausprägung)” before continuing:

“[1] …who are very achievement-oriented, who push themselves in great measure to have successes and who, depending on competencies, are also successful.

[2] … who have landed in a life phase where they no longer feel committed to its (for them binding) demands and in which they ‘invest’ effort and markedly develop a feeling of failure (which they also sometimes objectively do).

[3] … who are achievement oriented to a limited degree or not at all, who nevertheless show high standards that they should actually fulfil, and they compensate for the discrepancy between actual achievement and their standards with fantasies or ‘exculpatory strategies’: ‘You really have many capabilities, but were always handicapped. If you hadn’t been handicapped, you’d be a lawyer today. So you’re practically a lawyer and also want to be treated like one’” (18).

As we might expect, these types are successively more difficult to treat, with success-less narcissists being “highly therapy-resistant”, and crashed narcissists requiring “different therapeutic emphases” (19). These are “something different [from overt and covert narcissism]” in the opinion of a COP clinician (DE-CP-6, 25.02.2014). “All three types are variants of narcissism, i.e. (d.h.) all three types fulfil certain definitional criteria” (Sachse et al. 2011:19), however. Shared is a
“double self-schema,” where one is positive (grandiose) and the other negative (vulnerable):

“... and they exist parallel, right, and the negative schema basically causes the person to remain sensitive to criticism, every criticism activates this schema. And the positive schema brings one to boast relatively often, so that one presents oneself relatively strongly positively, and I believe that the negative schema also causes one to compensate through achievement.” (DE-CP-6, 25.02.2014)

Similarly residing somewhat between sociology and psychiatry was a social worker using systemic therapy (DE-PP-1). He described people with a “narcissistic disposition” (his term) as “frequently seeking out dyadic relationships, with the tendency then to try and keep the outside world at bay” (11.03.2014). “There’s relatively little altruistic thinking, rather they use relationships to stabilise their own self-worth” (DE-PP-1).

(II.4) Related Phenomena: Narcissistic Rage and Narcissistic Injury

Two methodological missteps were made inquiring about narcissistic rage and injury. In both cases, I did not probe consistently. I asked only psychodynamic Americans about rage, and fared little better with injury. A CBT inclined practitioner (DE-P-1) mentioned both narcissistic conflicts and crises. Interesting here is his agreement with an interpersonally-oriented clinician (US-CP-1) that narcissistic conflicts or injuries occurred in normal people. “[D]isappointments to our normal motives to achieve” or failure to satisfy “the motive to self-enhance, to experience self-enhancement” (US-CP-1, 6.06.2013) are the usual causes. Another informant (US-CP-5) preferred to call them “threats to self-esteem” because otherwise it was “a little jargon-y,” and also saw narcissistic conflict as coming when “self-perception and other’s feedback are not in line” (15.05.2014). In all people, the problem is one
of “acceptance”, that “the deeper core (Kern) can’t call forth the capacity to actually work through the reality” (DE-P-1, 11.02.2014). Similarly, “narcissistic injury is happening more frequently [in pathological narcissists], and you’re more vulnerable to it. It’s a bigger fall because your expectations are so high” (US-CP-1, 6.06.2013).

A more biologically-oriented clinician (US-P-2) independently mentioned narcissistic injury, but only defined it negatively:

“[W]hen [NPD] patients get depressed because of a narcissistic injury, for example, sometimes that depression may have some of the neurobiologic substrates that make it conducive to treatment with an antidepressant. But sometimes they don’t lead to that kind of thing. If it’s narcissistic injury, it doesn’t necessarily respond to an antidepressant.” (11.07.2014)

Narcissistic rage was generally thought of as an attempt to restabilise self-esteem after a narcissistic injury (CA-CSW-1, US-CP-5, US-CP-11) or as “one of several emotions that can be dysregulating, that they’re unable to contain” (US-CP-1, 6.06.2013). It can be “turned inward or outward” (ibid), and more impulsive or “contained and connected more with agency or planning, something associated to revenge” (US-CP-5, 15.05.2014). It can “be subjectively felt and experienced” (US-CP-11, 19.05.2014), for example “having some fantasy that they'll get their just desserts somehow, there'll be some kind of comeuppance that will even the score” (CA-CSW-1, 6.09.2013).

(II.5) DSM: The Official Version

Unsurprisingly, a substantial number of respondents (A-P-1, CH-P-2, DE-CP-1, DE-CP-3, DE-P-1, US-CP-1, US-CP-7, US-CP-8, US-P-2) referred to the DSM definition of NPD when discussing how they understood or diagnosed it. For the information of the lay reader, I reproduce DSM-5’s diagnostic criteria here:
“A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognised as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes he or she is ‘special’ and unique and can only be understood by, or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e. unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitative (i.e. takes advantage of others to achieve his or her ends).
7. Lacks empathy: is unwilling to recognise or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.

While there have been changes to NPD’s criteria over time, I’ll not review these (see Reynolds & Lejuez 2011). The alternative model for PDs (APA 2013:761-781) is relevant both because of the controversy it generated during the revisions, and the responses it provoked in my informants.

NPD has the following “proposed diagnostic criteria,” with Criterion A addressing
“personality functioning”, where “[m]oderate or greater impairment” was
“manifested by characteristic difficulties in two or more of the following four areas”
of identity, self-direction, empathy and intimacy:

“1. **Identity**: Excessive reference to others for self-definition and self-esteem
regulation; exaggerated self-appraisal inflated or deflated, or vacillating between
extremes; emotional regulation mirrors fluctuations in self-esteem.

2. **Self-direction**: Goal-setting based on gaining approval from others; personal
standards unreasonably high in order to see oneself as exceptional, or too low based
on a sense of entitlement; often unaware of own motivations.

3. **Empathy**: Impaired ability to recognise or identify with the feelings and needs of
others; excessively attuned to reactions of others, but only if perceived as relevant to
self; over- or underestimate of own effect on others.

4. **Intimacy**: Relationships largely superficial and exist to serve self-esteem
regulation; mutuality constrained by little genuine interest in others’ experiences and
predominance of a need for personal gain” (APA 2013:767).

Personality functioning was itself a novel contribution of this alternative model, but
NPD distinguishes itself further. In identity, we see an allowance for vacillation or
unrealistically negative self-appraisals. Empathy is upgraded from a pervasive lack
to “an impaired ability for.” The possibility of attunement for personal gain is now
in the manual itself, rather than only in a structured interview guide (First et al.
At first blush, Criterion A looks and feels much like the DSM-IV definition: it has a cut-point (2/4), and combines many of the old criteria. Impairment is now assessed dimensionally for each of these four areas of self and interpersonal functioning: hence levels of personality functioning (APA 2013:762, 775-778). A blanket reminder to regard “an individual’s developmental stage or sociocultural environment” (ibid:761, Criterion G) has been grafted onto the general definition for PDs in the alternative model. Criterion A, no matter if the severity is moderate or greater, may be “the core of personality psychopathology” but it is only predictive:

“Impairment in personality function predicts the presence of a [PD], and the severity of impairment predicts whether an individual has more than one [PD] or one of the more typically severe [PDs].” (762)

Enter Criterion B, pathological personality traits. These clinch the deal. While other specific PDs have more traits listed than are required, NPD has only two traits and both must be present:

“1. Grandiosity (an aspect of Antagonism): Feelings of entitlement, either overt or covert; self-centredness; firmly holding to the belief that one is better than others; condescension toward others.

2. Attention seeking (an aspect of Antagonism): Excessive attempts to attract and be the focus of attention of others; admiration seeking.” (APA 2013:768).

Finally, NPD also has an allowance for specifiers, or further traits over and above these required two which specify the individual’s presentation. These include “other traits of Antagonism (e.g., manipulativeness, deceitfulness, callousness)” or “of
Negative Affectivity (e.g., depressivity, nervousness)” (ibid:768). Both traits (ibid:770) and levels of personality functioning are conceived of dimensionally, but some separate categories remain. The alternative model is therefore also referred to (sometimes disparagingly) as a hybrid dimensional-categorical model.

Clinicians varied in how closely they hewed to the manual, ranging from “not that different from the DSM” (US-P-2, 11.07.2014) to overlapping understandings to definitions adding in an aetiological component. Some pointed directly to the DSM definition without any qualifiers (CA-P-1, DE-CP-3), whereas others generally added some hedged negativity. Concisely capturing the consensus of the two CBT practitioners (DE-CP-1, DE-P-1) was the younger, who said, “[T]hough I also know that narcissism isn’t very well covered by DSM, but that doesn’t allow me to invent my own diagnostic instrument, right?” (DE-CP-1, 5.03.2014). Psychodynamic informants tended to view DSM NPD as a rump, representing one particular narcissistic pathology (e.g. CH-P-1, US-CP-1). Efforts to lessen overlap and improve reliability “led to the lopping off over the years of anything that really had to do with the vulnerability, the affective dysregulation, the self-dysregulation, the negative affects – the things that actually make narcissists miserable” (US-CP-1, 6.06.2013).

An overlapping definition is exemplified by an Austrian psychiatrist’s (A-P-1, 20.02.2014) mnemonic: “[T]he main indicators (Hauptkennzeichen) are, as I say in German, the five big E’s, namely: Egozentrik (ego-centricity), Eigensucht (selfishness), Empfindlichkeit (sensitivity) – so irritability, Empathiemangel
(empathy impairment), and *Entwertung* (devaluation) of other people.” He went on to say that “the scientific criteria of the DSM-5 [are] somewhat more thorough, exacter, and yeah, but I agree with them overall” (20.02.2014). An interpersonal practitioner pointed to the “interpersonal summary” of NPD in Benjamin (2003):

“There is extreme vulnerability to criticism or being ignored, together with a strong wish for love, support, and admiring deference from others. The baseline position involves noncontingent love of self and presumptive control of others. If the support is withdrawn, or if there is any evidence of lack of perfection, the self-concept degrades to severe self-criticism. Totally lacking in empathy, these persons treat others with contempt, and hold the self above and beyond the fray.” (391-392)

CBT is similar in that it proposes a way of discriminating the PDs (namely dysfunctional beliefs, Beck et al. 2001; cf. Beck, Davis, & Freeman 2015:46, 54-55 on under and over-developed strategies), but is less specific on aetiology (compare Beck 1998:174 and Benjamin 2003:143-147).

ST saw itself as compatible with DSM though “much more wedded to the idea that it does happen along a spectrum” (US-LCSW-1, 16.09.2013). A German psychiatrist (DE-P-2) who used this approach said, “one could actually make an exception for narcissism, and say that it’s a disorder even if the distress can be considerable for the environment” (20.12.2013). The considerable difference from CBT and interpersonal therapy came in their conceptual language. A “detached, self-stimulating mode” and an over-compensatory mode were said to be the primary ways narcissists had of dealing with “their vulnerability or loneliness” (US-LCSW-1, 16.09.2013). In this connection, we understand why schema therapists might say things like, “I believe that actually there’s a very small child-self in the foreground” and “it’s always about protecting myself, no matter from whom” (DE-PP-1,
3.02.2014).

The muscly man in the mist is of course the ICD-10, which relegates NPD to a residual category, suggesting low importance (WHO 1992):

“F60.9 Other specific personality disorders
A personality disorder that fits none of the specific rubrics F60.0-F60.7.

Includes: eccentric, ‘haltlose’ type, immature, narcissistic, passive-aggressive, and psychoneurotic personality (disorder)” (207).

What this means is that non-US clinicians who see NPD or pathological narcissism as an issue are forced to use either the DSM or some other classificatory scheme. Definitions of pathological narcissism are often common to a psychotherapeutic school (see above on CBT and interpersonal therapy).

Aetiology was infrequently pursued, though it sometimes emerged unexpectedly. When I asked a more biologically-minded psychiatrist if we could learn about the neurobiological correlates of NPD from studies of its Cluster B kin (antisocial and borderline PD), he began (US-P-2, 11.07.2014) by questioning whether those where the best near-neighbours. Noteworthy was his description of NPD as “sort of a high-level antisocial disorder,” distinguished by a lack of psychopathy and overt aggression. “ADHD and bipolar spectrum” illnesses were nominated by him as perhaps better relations. Earlier in the interview he had explicitly stated that there
was a “biological link” between bipolar and NPD.

One practitioner (US-CP-2, 10.05.2013) postulated the origins of NPD in the meeting of “[b]road temperamental differences” with “narcissistic processes that have been learned, developed, and shaped over years” overlaid. Particularly environments where “it’s really bad to make a mistake” and “in the family a lot happens with valuation, up and down” were seen as potentially leading to narcissism by a Gestalt therapist (DE-CP-2, 8.01.2014; cf. DE-CP-4 and US-PP-3). A similar, social-learning aetiological theory was proposed by a relational psychodynamic clinician (CA-CSW-1, 6.09.2013). The major difference was that these “narcissistic defences and mechanisms that they've had to rely upon” came about as a way of coping with a lack of carer empathy and mentalisation (“the capacity to think about one's own mental contents and also about the contents of other peoples' minds as well”) early in life (6.09.2013; cf. US-PP-1, 23.05.2013). Although such views were mainly held by psychodynamic practitioners, one CBT-oriented clinician pointed to research indicating that “the Kernberg and Kohut model is the more realistic one” (DE-P-1, 11.02.2014).

Several practitioners held an explicitly Kohutian understanding of narcissism, involving a developmental lag (DE-CP-5, US-PP-2 and -3). One clinician (US-CP-4) mentioned this lag, but also said he thought about “narcissism as a very core feature of psychopathology which cuts across many other conditions. To me, it’s sort of a signal of how mature or primitive one’s personality is” (21.04.2013). Later in the conversation, he elaborated: “[I]t could be that, in other words, vulnerability is
the core of ALL [PD], and that people have different kinds of reactions to
provocation, right?” (21.04.2013). Key to a more orthodox Kohutian
conceptualisation is the notion that “narcissism [isn’t] a pathology necessarily” (US-
PP-3, 9.05.2013). A German (DE-CP-5) told me Kohut described two types of
narcissist: “someone who’s of the opinion that they’re great and the whole world
already knows it, …, and the others are the ones who must idealise, who attribute this
preconception of greatness to others” (4.03.2014).

Several others gave Kernberg’s definition of narcissism (e.g. DE-CP-4, US-CP-6,
US-P-3). One psychiatrist (US-P-1) gave a succinct summary of the structure:

“[NPD] is based on a self-structure where in response to an
unintegrated, sort of incoherent and thus very disturbing core sense
of self. The individual has found a way, obviously unconsciously,
to try to put together everything that is ideal into the self-concept.
The good qualities are merged and they can tack onto and include
some actual, real attributes of the self, but everything that has a
negative valence is projected, is perceived as other. So the person
interacts with the world with this pathologically grandiose self
colouring every interaction and a devaluing attitude towards other.
This pathologically grandiose self clearly doesn’t allow for in-
depth reality checks, it doesn’t respond to the reality of the
surrounding world. Therefore to protect this pathological
grandiose self-structure and defend it, the person of necessity can
only have very superficial relations with the world around them
because the deeper contact is too much of a challenge to the
grandiose self-structure, which of course can break down anyway.”
(22.05.2014)

Important in Kernberg is aggression. In addition to Rosenfeld’s thick- and thin-
skinned narcissists, Kernberg sees what he terms as malignant narcissists. The same
informant didn’t use the term, but mentioned that:

“At the lower levels of narcissistic pathology, the aggression
combined with the envy can lead to extremely hostile stances
towards others in the world where the other can be seen as someone
in relation to whom the main gratification is to defeat or triumph
US-P-1 referred to these as being the “sickest narcissists” (22.05.2014). Beyond more typically Kohutian or Kernbergian understandings of pathological narcissism, there were a wide range of other psychodynamic understandings.

Many psychoanalytic clinicians (DE-Ps 4, 5, 6, 8, 10, and 12; US-CPs 5 and 11) orbited around a hard-core definition, though all had elaborations. The basic issue is self-esteem regulation. Shame and impaired empathy were seen by some to be defining difficulties (DE-P 5, 8). One informant (DE-P-12) described NPD “in the narrow sense” as containing “a noticeable incapacity for forming relationships, the predominance of unconscious envy, and of very extreme valuation tendencies and splitting...” (17.02.2014). He added that “mostly somewhere manifest defence, and an extreme allergy against coming into contact with depressive content” (17.02.2014).

One German (DE-P-3), self-identified as “psychoanalyst, specialising in psychotraumatology” who had nevertheless “withdrawn [himself] from the local psychoanalytic scene” (13.01.2014), had quite an idiosyncratic definition of narcissism. In his understanding, it was “questing for harmony, for a harmonious world without conflicts, without annoyances, without anything foreign” (13.01.2014). He said that the apparently inflated self-esteem was actually “a feeling of anomie, because there’s no better and no worse, there’s only unity here” (13.01.2014).
Several Europeans pointed out that narcissism could be situative (CH-P-2). One (DE-P-10) pointed to elites in industry and elsewhere, and gave the example of fighter pilots, commenting:

“I'm certain that if you experience these people who come across as very narcissistic in another situation, in another context, then at the least they wouldn't have come across so narcissistically. So I believe that contextualising the diagnosis with the patient is of supreme importance and is part and parcel of it.” (21.03.2014)

An Austrian psychiatrist (A-P-1) stressed that part of diagnosis was to rule out what he called a “narcissistic reaction,” which seemed to be his term for an individual’s response to a narcissistic injury.

(III) A View from Above: Patients Treated and Essential Readings

There are reasons, however, that clinicians perceive these irreconcilable rifts between schools. A simple empirical demonstration can be found in clinicians’ estimates of how many narcissistic patients they’ve treated.

<table>
<thead>
<tr>
<th>Estimated narcissistic patients treated</th>
<th>Code</th>
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<tbody>
<tr>
<td>1</td>
<td>DE-CP-1</td>
</tr>
<tr>
<td>&quot;including less intensive contacts, I'd say 20&quot;</td>
<td>DE-PP-1</td>
</tr>
<tr>
<td>&quot;let's say 50&quot;</td>
<td>DE-CP-2</td>
</tr>
<tr>
<td>&quot;I've always had two or three in treatment. If the total is 30 or 40 or 50, I really couldn't tell you. Clinically, in-patient, you see them fairly often but I don't treat them, there I ultimately just see them.&quot;</td>
<td>DE-P-1</td>
</tr>
<tr>
<td>&quot;Round about 10.&quot;</td>
<td>DE-PP-2</td>
</tr>
<tr>
<td>50, 60, 70.</td>
<td>DE-P-2</td>
</tr>
<tr>
<td>Inpatient &quot;over 100. More intensive, outpatient therapy… around 15.&quot;</td>
<td>CH-P-1</td>
</tr>
</tbody>
</table>
"To estimate, we didn't precisely measure, then 90% of patients have narcissistic issues. I'd estimate the real, undeniable, severe narcissistic personality disorder that one diagnoses as such to be 10% [of patients]."

"Outpatient maybe 20 to 30, and in-patient surely a hundred…"

"Certainly hundreds."

"Could'n tell you…"

300, 400 patients in the day-clinic (partial-hospitalisation programme), and "long-term psychoanalyses… maybe another 20."

"… I'd guess around 25, but that could be a misperception [Wahrnehmungsfehler] because the topic is so often in my thoughts that I'm overestimating that right now."

"Twenty of them in longer treatment." Including in-patients and supervision, "Then we can add maybe another 80 to 100 on top."

"Certainly several hundred patients"

"30?"

"I can't say…"

Thousands

"200? 250? Something in that neighbourhood."

"Advised or briefly treated… 100, 200? … maybe a dozen really long-term therapies."

"In the sense of an assessment [Diagnostik] and referral? Certainly several hundred. … Personally treated, over a number of years, as we do in psychoanalysis, not many. 2 or 3. 4 maybe."

334, "In long-term treatment, five."

"15, 20?"

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<table>
<thead>
<tr>
<th>Estimated Narcissistic Patients Treated</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>30-40</td>
<td>US-CP-1</td>
</tr>
<tr>
<td>&quot;Probably five where it's the dominant issue... and another three to five, where it's been noticeably present, but not the main organising theme of their personality&quot;</td>
<td>US-CP-2</td>
</tr>
<tr>
<td>&quot;No idea&quot;</td>
<td>US-CP-3</td>
</tr>
<tr>
<td>&quot;Only one patient…formal diagnosis&quot;, 16-20 with &quot;issues related to pathological narcissism&quot;</td>
<td>US-CP-4</td>
</tr>
</tbody>
</table>
"DSM point of view… relatively few"

"50, 70, something like that"

"Quite a few hundred"

"Dozens and dozens"

"If I include all those [short-term] patients, it might be 50 people. Not a lot."

"Thirty patients for a combined total of sixty years or something like that."

"I mean, everybody has personality issues, right? (CFD laughs.) I would say 100% of my patients come in with some sort of dynamic, personality pattern, but if you’re asking how many are identified cleanly in some as being narcissistic and that’s their main issue… I can’t, it would skew your results for me to try and give you some sort of percentage, because I’d be just picking out a number, I think."

Hospital - "not very many." Private practice - "Maybe half a dozen, mostly because they won’t come to see me because I get right down to work and they’re not usually in the mood for it."

"Total, maybe thirteen or fourteen" (Treated two and "probably a third," assessed ten, and one neuropsychological assessment)

"I would say… seven?"

"So I would say two dozen or so? … Again it’s hard to say because there’s some folks who come in, are there for a short time, and then they leave. So it may be more than a couple dozen. In terms of really getting into treatment and getting into issues with them, I think that’s a good estimate."

"Say – I don’t even know how many patients I’ve treated over the course of my career, I don’t know that I’ve ever counted. If you count in people with narcissistic issues as well as narcissistic personality disorder, I would say it’s about half the patients I treat, and how many of them successfully? Well, success is a relative term."

"I am not sure exactly how many I have seen in consultation and/or treated in that time period, but I would make a fairly confident guess that it’s greater than 200. Narcissists certainly comprised at least 75-85% of my practice [up until 2013], mostly male patients and some females (probably 85/15 split)."

<table>
<thead>
<tr>
<th>Work</th>
<th>GE</th>
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<tbody>
<tr>
<td>Campbell &amp; Miller 2011</td>
<td>2</td>
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<tr>
<td>Freud 1914</td>
<td>3</td>
<td>1</td>
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<tr>
<td>Work</td>
<td>Location of endorser</td>
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<td>----------------------------------------------------------</td>
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<tr>
<td>Beck, Davis, &amp; Freeman 2015</td>
<td>NA</td>
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<tr>
<td>Benjamin 1987</td>
<td>NA</td>
<td></td>
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<tr>
<td>Benjamin 2003</td>
<td>NA</td>
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<td>Clark 2007</td>
<td>NA</td>
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<tr>
<td>Clarkin, Yeomans, &amp; Kernberg 2006</td>
<td>NA</td>
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<tr>
<td>Denke &amp; Hilgenstock 2008</td>
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<td>Fiedler 2007</td>
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<tr>
<td>Fonagy et al. 2003</td>
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<td>Green 2001</td>
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<td>Hotchkiss 2008</td>
<td>GE</td>
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<tr>
<td>Kernberg 2004</td>
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<tr>
<td>Kernberg 2007</td>
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<tr>
<td>Kohut 1977</td>
<td>GE</td>
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<td>Lacan 2001</td>
<td>GE</td>
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<tr>
<td>Levin 1993</td>
<td>NA</td>
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<tr>
<td>Linehan 1993a</td>
<td>GE</td>
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<tr>
<td>Masterson 1990</td>
<td>GE</td>
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<tr>
<td>McWilliams 2011</td>
<td>NA</td>
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<tr>
<td>Morey et al. 2012</td>
<td>NA</td>
<td></td>
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<tr>
<td>Millon 2011</td>
<td>GE</td>
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</tr>
<tr>
<td>Oldham &amp; Morris 1995</td>
<td>GE</td>
<td></td>
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<tr>
<td>OPD Task Force 2008</td>
<td>GE</td>
<td></td>
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<tr>
<td>Ovid, Metamorphoses</td>
<td>GE</td>
<td></td>
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<tr>
<td>Pincus et al. 2009</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Rafaeli, Bernstein, &amp; Young 2011</td>
<td>NA</td>
<td></td>
</tr>
<tr>
<td>Reinecke, Dattilio, &amp; Freeman 2006</td>
<td>NA</td>
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</table>
We would expect a range of estimated narcissistic patients based on the differing experience levels of my informants. I find, however, that we cannot explain this on the virtue of exposure alone. Theory seems to play a part here, as suggested by the wide range of recommended texts and the high number of worked mentioned by a single respondent. Having established the field’s diversity, we turn now to diagnosis.
Chapter 5: Dissecting Diagnosis: Post-Mortem of a Process

“Start with the self-report, if I get the sense that there's vulnerability, which again usually there [is], and I guess the main indicators of that for me would be the overall distress on the [Inventory of Interpersonal Problems] by informant report or self-report. The borderline scale of the [Personality Assessment Inventory], I think is a pretty good measure of vulnerability. Then I might give the [Pathological Narcissism Inventory], [Pincus’] measure, which has more specific kinds of vulnerability as well as grandiosity.”

(US-CP-4)

Conceptualisation drives diagnosis, which is itself a multi-stage process. Theory orders the hodgepodge of facts coming in from what the pre-patient says and how they respond to questionnaires or structured interviews. Indeed, it decides what tools will be appropriate to disentangling the mess to create a guide for treatment. Each stage of assessment signifies a particular relationship to be negotiated. Models of these interactions are, I suggest, inherent in every theory. As the variety of definitions in the previous chapter would imply, diagnosis ought to show the clearest boundaries between psychotherapeutic traditions. There is greater distinction here than in treatment or research, but we nevertheless find unexpected likenesses. Competition and self-interest are to be found, though they will not be foregrounded. Let us now turn to the analysis of our introductory example.

In a few sentences (US-CP-4, 21.04.2013), we are plunged into the perilous plumes of psychiatric diagnosis (cf. Young 1995:145-149). PDs are notoriously more
difficult to discern, but we see here three different scales and two forms of data collection. Conceptualisation emerges at the outset, in the form of these miscellaneous measures. Both the Inventory of Interpersonal Problems and the Personality Assessment Inventory draw on interpersonal theory: in brief, people and their relationships can be described in circumplex space, with the horizontal axis measuring communion (or warmth) and the vertical assessing agency (e.g. from dominance to submission). They diverge in that the IIP tends to measure symptoms whereas the PAI is more trait (structure) oriented. The PNI (Pincus et al. 2008) is a measure specific to narcissism.

But what of these self and informant reports? When we think of psychiatry, we often imagine interviews. These aren’t the only element, though they are a central component of the diagnostic process. Self-report refers to a form filled in by the pre-patient. An informant report is when a pre-patient’s familiar (e.g. partner, co-worker, or friend) is invited in and fills in a form related to the other person. NPD is often experienced as ego-syntonic, or in other words, oftentimes it doesn’t cause the pre-patient subjective distress. With PDs more generally, patients frequently see others – as opposed to themselves – as the source of their troubles (e.g. US-CP-4, 3.05.2013). An outside perspective, and thus triangulation, is often seen as beneficial by clinicians.

“Grandiosity” and “vulnerability” can appear more opaque to outsiders. Vulnerability might be summarised as emotional reactivity, a sensitivity to interpersonal stressors. In particular, narcissists are highly vulnerable to perceived
criticism, shame, or situations in which they feel inferior. We might describe them as having easily profaned selves (Goffman 1967:31-32) or by reversing Goffman’s dictum: for the narcissist, “maintenance of face is [an objective] of interaction, not its [condition]” (1967:12). Grandiosity describes a belief in one’s inherent superiority, which may be seen as compensatory or cardinal. By cardinal, I mean that the individual is convinced of their own high worth. ST, for instance, suggests that “patients with ‘pure entitlement’ were simply spoiled and indulged as children, and continue to act that way as adults” (Young et al. 2003:237). Sociologically, we would expect grandiosity to manifest itself in an expectation of automatic deference, or “that component of activity which functions as a symbolic means by which appreciation is regularly conveyed to a recipient of this recipient” (Goffman 1967:56). Goffman (1967) would also suggest that self-centredness and self-consciousness needn’t always carpool in conversations (118).

I propose that diagnosis is not a simple act, but rather a five stage process. This method can be schematised with five D’s: (1) discovery, (2) distinction, (3) discussion, (4) dispersion, and (5) direction. Through the remainder of this chapter, I’ll proceed through each phase, step-by-step, to articulate universalities and underscore difference. Though my respondents only used the translation metaphor in relation to what I call discussion, different sorts thereof occur throughout this sequence. Diagnosis is a theory-guided process: concepts serve to order the jumble of a pre-patient's biography, and guide the clinician's hand by providing patterns for the various relationships entailed in the assessment's progression. Assessment is arguably the most differentiated (compared to treatment or science), but even here
we find substantial similarities across the psychotherapeutic spectrum. In other words, the minor differences of narcissism begin the moment the pre-patient enters the consulting room.

![Figure 5.1 Diagnosis as process](image)

**Figure 5.1 Diagnosis as process**

Fusion of the ritual and the rational begins at that self-same moment. Rosenberg (2002:240) explicates that diagnosis “constitutes an indispensable point of articulation between the general and the particular, between agreed-upon knowledge and its application.” Furthermore, it is a ritual linking not only patient and practitioner, but also “the emotional and the cognitive.” He goes on (ibid) to continue that these linkages:

“… legitimat[e] physicians’ and the medical system’s authority while facilitating particular clinical decisions and providing culturally agreed-upon meanings for individual experience. Not only a ritual, diagnosis is also a mode of communication and thus, necessarily, a mechanism structuring bureaucratic interactions.”

We find several other definitions emphasising the complexity of diagnosis in the literature (see also Godderis 2011; Goodwin & McConnell 2014; Sulzer 2012:Ch. 5).

---

25 Joe Cortez formalised this diagram.
I now explain the 5-D model of diagnosis illustrated above.

Under discovery, we find the typical diagnostic apparatus – gathering (differently defined) data to reach a hypothetical conclusion. Traditionally, parts (1) and (2) are lumped together under diagnosis. While in practice these are virtually indistinguishable, distinction (or differential diagnosis) is analytically separable from data collection. Both stages involve clinical judgment, but the orientation and location differs. In discovery, data are sifted and a pattern pulled out. The focus here is on the patient, or the practitioner-patient interaction. Distinction pits the abstracted pattern against the clinician’s stock of knowledge. While we move here into the clinician’s mind, arguably the relationship is to other practitioners – mentors, colleagues, and individually complementary and contesting classificatory schemes.

Symptoms are translated into technical (i.e. theoretical) terms. Discovery directs the clinician’s eye towards relevant behaviours for this by way of theory. It translates the symptoms into a flowchart or ordered list, which then is input into distinction. These images are compared against prototypes from one (or more) conceptual systems, and then emerge as a hypothetical diagnosis.

Discussion is ritual: again dyadic, local, and ‘embodied’. Theory, however, dictates the topic and boundaries of the conversation. Translation here is literal: it makes the psychiatric jargon understandable to the patient. A chance arises for induction into the patient role. Dispersion is more than labelling, or a title’s transmission to relevant parties (intimates, insurers, etc.): we encounter varying reactions to a
diagnosis.

Diagnosis is sent out into the world, but it is first rendered into bureaucratically or locally useful terms. With translation, dispersion represents the stage of assessment where politics or decontextualisation find expression. Practitioners do disparage, there seem to be good sociological reasons for their bad behaviour. I argue that dispersion stage reveals an undercoat-overcoat model of moral valuation. Finally, in direction, we see how diagnosis channels treatment. Here practitioners convert accomplished diagnoses into treatment goals and potentially also techniques. Translation ought to be borne in mind as we transition from step to step in the process. Figure 5.1 schematises the 5-D diagnostic procedure as I have sketched it here.

My debt to Godderis’ (2011:141) flowchart of the “psychiatric diagnostic work process” seen earlier is obvious. I present this simplified and slightly altered version for three reasons. First, treatment leads to new information, potentially restarting the cycle, excepting dispersion. Second, Godderis’ figure doesn’t indicate the amount of interaction between patient and therapist in assessment. Third, direction, which I consider a key stage in the process, is only implied in her diagram. I stress also that the overlap between dispersion and direction is intentional: outflow begins earlier, but co-occurs with channelling. How the practitioner relates with outside parties to whom the diagnosis must be conveyed is determined by some of the same factors which drive the treatment in a certain direction.
In my usage, diagnosis will refer more to the category, and assessment to the process. They will to some extent be used interchangeably. I feel my informants’ not seeing these as very different terms lends some credibility to this convention.

(I) Discovery, or “It’s not like asking a patient if they hear voices or not.”

A clinical social worker (CA-CSW-1, 6.09.2013) underscored how arduous an assessment for pathological narcissism can be with the above quote. One psychoanalyst (US-CP-5) emphasised translation, asserting that “sometimes it can be quite a piece of work to gradually figure out the way the patient sees their narcissistic problems, how to translate that into both a diagnosis and how to treat it” (15.05.2014). While this quote combines discovery and distinction, we see that the pre-patient’s lived experience is neither immediately nor simply slotted into symptom-shoeboxes. Models give clinicians a way of transforming complex behaviours and seemingly stupefying patterns into a clinically-useful picture. What theory does is somewhat analogous to clamps and suction in surgery: it gives the clinician and the client a clear field of vision.

A plethora of practical points must be considered in how discovery is carried out, for instance: (i) how quickly it can be conducted, (ii) severity of the illness, (iii) symptoms which might speak for or against the diagnosis, and (iv) what instruments one employs in assessment. While there are many other imaginable angles, I focus on these themes as they emerged from my interviews. Examining these aspects of discovery enables us to see similarities we might otherwise overlook. Theory most
notably impacts one’s choice of instrumentation, though its role will be explored in all these procedures. Let us begin with how quickly one can spot a narcissist, as this yields our first likeness.

(I.1) Diagnostic velocity

Speed with which one can recognise pathological narcissism seems to be minimally impacted by theory. Most respondents who commented on this stated that it could be highly variable. Typical of these replies was US-CP-2:

“I think narcissistic pathology can, depending on the degree of it, depending on how it's manifesting, it can either smack you right in the face and you can see it right away or it can be the kind of thing that emerges a little bit slower, a little bit later, only as you start to realise why someone is doing things.” (10.05.2013)

Another American stressed that recognition in self-referring outpatients is typically slower (US-CP-1, 6.06.2013), whereas court-mandated or forensic patients tend to have more outwardly evident narcissistic pathology (5.10.2015, email).

Three individuals in the broader CBT line diverged on this point. The American (US-CP-3) emphasised the relative ease if one was attentive:

“But he looks around [my office], and he said, ‘For what I'm going to be paying you, I'd think you'd have nicer furniture. (CFD laughs) I can give you the name of my decorator.’ So, you know, your first response is, ‘Fuck you,’ like, ‘Who needs this shit?’ But this is his first contact with me, so how can I miss – I mean, this is an assessment.” (2.08.2013)

A more research-oriented German CBT practitioner (DE-CP-3, 22.01.2014) explained that, “I think more than one or two or even more contacts are necessary to be allowed or able to give the diagnosis.” It is unclear whether these practitioners differed because of experience, or due to the German’s
scientific focus. Research criteria are by necessity stricter than clinical ones, but young clinicians are often more stringent in adhering to disciplinary norms. Both, therefore, likely helped to shape this distinction.

Somewhere between them was a clarification-oriented psychotherapist (DE-CP-6, 25.02.2014):

“When you ask, ‘So, what brought you here?’ or ‘What’s troubling you?’ then typically narcissists will say, ‘I don’t have any problems, actually, I just want coaching’, or ‘I want to further develop myself’, and principally, the first thing they say, they spend at least ten minutes talking about how terrific they are. And that means that you recognise 90% of narcissists in the first ten minutes.”

Here we confront subjective distress once again. This informant indicated that typically psychotherapy begins with some presenting problem, a “request” on the patient’s part. Narcissists are therefore distinct in two ways from his typical clients: they frame their visit in terms of self-optimisation, and early on they demonstrate a need to impress the clinician. A COP manual suggests another unique pathway to therapy for narcissists, referral by other clinicians\(^{26}\), e.g. a cardiologist (Sachse, Sachse, & Fasbender 2011:75). COP conceptualises narcissists having a double self-schema: one positive (often based on real accomplishments), and one negative, running parallel. The compensatory function of the positive self-schema is seen in the act of persuading the therapist of one’s worth, and the theory would suggest that this is because negative self-assumptions were activated by the act of coming to seek ‘professional help’. Given that one sceptic described COP practitioners as having “a far lower [diagnostic] threshold,” it seems reasonable to believe that the dissimilarity

\(^{26}\) No North Americans reported non-therapist referrals.
is here due to theory. The double self-schema gives the COP clinician a prototype, which is seen (at least by this practitioner) as trustworthy. In contrast, the research-oriented CBT clinician and sceptic doubt intuition. Their model is to seek verification or disconfirmation. What differentiates the COP and sceptical clinicians, I suggest, is their tolerance for templates. Severity, we might predict, ought to be fairly independent of theory. But we see that here, too, conceptualisation provides a frame of comparison and means of understanding.

**I.2 Illness intensity**

Severity was infrequently discussed in relation to assessment. A trainee who considered himself predominantly psychodynamic suggests how one’s therapeutic approach influences understandings of an illness’ acuteness:

“[D]iagnosis versus sub-threshold does not indicate severity of narcissistic pathology. It really just says that they have more of this presentation that’s in the DSM, that we can diagnose that part. But to get at severity I think we need to think in other ways. Because I’m trained dynamically, I think in object relations which says that if they’re able to integrate views of self and others, if they’re able to use defences to regulate internally rather than try to regulate their outside world, then they’re a little bit more adaptive and less severe than the cases where they’re unaware that they’re doing stuff. They’re pissing people off in their life, they’re not having a clear sense of themselves or a clear sense of others, that gets more pathological. But that’s not based on the distinction NPD diagnosis versus not.”

(US-CP-9, 6.06.2013)

While DSM could hypothetically deal with this (global area functioning in DSM-IV, and the WHODAS and personality functioning in DSM-5), it is striking that a more theoretically-resonant measure of severity is used. The criterion list for NPD is seen as partial, incomplete, wanting. Symptoms seen as indicative should therefore vary by psychotherapeutic tradition. But do we find this when we ask clinicians what
they see when they observe pathological narcissism?

(1.3) Symptomology in Practice

It is trite but true to say that when we rule something in, we must rule something out.

What symptoms were seen as precluding a diagnosis of pathological narcissism?

Contraindications were typically mentioned by highly idiosyncratic psychoanalysts.

Another was an ST practitioner, and all were Germans. The schema therapist described it thusly:

“I’m not a fan of diagnoses in principle, anyway. One could of course say being empathic excludes narcissism, but the schema therapy approach (Ansatz) would say depending on which mode the patient activates, they can be empathic or not, for example.”

(DE-P-2, 20.12.2013)

Schema modes are an attribute unique to ST, and were developed in part to deal with the greater complexity of borderline patients (Young et al. 2003:40). They are defined as “those schemas or schema operations – adaptive or maladaptive – that are currently active for an individual” (37). In NPD, three modes are “by far the most common ones”, namely “the lonely [or vulnerable] child”, “the self-aggrandizer”, and “the detached self-soother” (374). Therefore, the same clinician continued:

“When a narcissist is in vulnerable child mode, then they can be extremely sympathetic, tuned in to the other, and be empathic. I’ve got many narcissistic patients with a self-sacrifice schema, that actually do want to rescue people no matter what. You can philosophise about it, ‘Are they doing it to inflate themselves?’ ... So I’d say, nope, there’s everything under the sun. Life is colourful and narcissists are colourful, and ultimately they can have any traits that other people have too.”

(20.12.2013)

We see here a broad agreement between ‘clinical wisdom’ of various schools and research findings. Ritter et al. (2011) indicate that narcissists are capable of
cognitive empathy (“the ability to take another person's perspective and to represent others' mental states”, 242) but not emotional empathy (“an observer's emotional response to another person's emotional state”, ibid). Elsa Ronningstam, a psychoanalytic practitioner, has stated that we should consider empathy “impaired” rather than “absent” in various publications and talks. While the correspondence is not 1-to-1, we can see an emergent consensus as to the features of narcissists’ empathic abilities. There are, at the coalface of practice, minor differences in narcissism – suggesting that there is some common object despite all the apparent variation.

Similarly, a more orthodox analyst in private practice proposed a relational contraindication, which would seem to fit with this image of empathy. Quality of romantic relationships was taken as indicative of patients’ level of psychological maturity or pathology. Given that it was a “spectrum disorder”, he had difficulty finding contraindications for narcissism. This distinction was similar to the diagnostic value accorded flat descriptions of significant others by Kernbergian (TFP) therapists, but concentrated on the representation of the relationship rather than the depiction of the ‘object’ itself:

“[I]f someone’s had a long-term romantic relationship where I have the impression it’s not much worse than my own, with arguments and all the accoutrements, and I also get the feeling of authenticity, that’s really important, that it’s not somehow wrong, perfumed, dishonest about the presentation of it, then I’d say this is a person with a mess of problems, narcissistic problems too, but not a narcissist.”

(DE-P-12, 17.02.2014)

The most exceptional response came from a psychoanalyst whose frame of reference was still relational, but far more localised. He stressed that positive and pro-social
feelings were incompatible with his vision of narcissism:

“[I]f I feel very excited, or full of ideas, when I feel very stimulated, or feel animated, or feel excited. If the impulse arises to do something cooperatively, in my understanding that can’t be identified with narcissism.”

(DE-P-3, 13.01.2014)

The same individual saw grandiosity as coming after narcissism, rather than being an inherent part thereof:

“Yes, grandiosity can of course only be experienced by the sufferer when the narcissism has already popped. So when you live in paradise, you don’t notice that you live in paradise. Only then when you’re tossed out. … They also get the diagnosis, not from me but from most of my colleagues. Those that I would describe as narcissists are still in that blameless state where it’s taken for granted that they’re wonderful, because they experience themselves as wonderful and only experience judgement when there’s already a tear.”

At the time, I was baffled: how could there be narcissism without grandiosity?

Within the context of compensatory models of narcissism, however, this could be conceived of as the first stage in this particular psychopathology. The centrality of recognising difference in treating narcissism across schools became clearer as I analysed the treatment data (see Ch. 6). I was similarly stumped by a description of the “paradoxical ways grandiosity can come about” (US-CP-2, 10.05.2013): “It's often, ‘I'm the worst off, I'm the most wounded and hurt and complex patient.’ It's not just, ‘I'm the king of the world,’ it can manifest itself in that way.” We see here something like ST’s “dependent entitlement” (Young et al. 2003:238).

Informants were emphatic about empathy and its incarnation in narcissists. Two informants stressed its situational nature still more strongly than the ST clinician quoted above. A psychoanalytic psychiatrist seemed offended when I asked about impaired empathy, cutting in and saying:
“Stop, stop. Oftentimes narcissistic people are extremely oblivious to others’ needs, and stomp across many boundaries. But it’s also the case that many protect themselves from being engulfed and overidentification, given that they very quickly comprehend others’ irritations and devaluing, and are very affected by it and so seek to protect themselves. It’s something dynamic, not a static function.”

(DE-P-10, 21.03.2014)

An equally active understanding came from a wholly different perspective. In response to a question about narcissists’ lack of empathy, another respondent said:

“[T]hat’s both right and wrong. It’s right when if you say there are people with poor self-integration, have very little empathy for the self, and also can’t immerse themselves in others’ needs because they’re not used to it, they didn’t learn how in childhood, maybe add in neglect, too few stimulating experiences. But I think that the core problem isn’t that there’s too little empathy on hand, but rather that it’s a habit not to sympathise with self and others, but the potential is in them. We’ve seen in research with so-called psychopaths, where we used to think the capacity for empathy was disturbed, but in the meantime we know that they can choose to turn it off, (CFD laughs.) just like a surgeon can. When they have to operate on or hurt someone, they can be unempathic too. They can learn that way of coping. So I think the capacity for empathy is there, just not properly employed.”

(DE-P-9, 12.03.2014)

We see here agreement not only across theoretical streams, but between neuroscience and clinical wisdom. Pathological narcissism has some shared substance, even if theory sometimes obscures this common ground. These understandings articulated by practitioners convey not just a “psychologising script” (Davies 2009:181), but a comprehension of patients as social creatures, more than psyches. A broad range of tools is employed in the clinic to glean data about symptoms not just inside in the person, but also in their interactional environment.

(1.4) Instruments of assessment

What does diagnostic procedure consist of, interactionally and materially? I’ll progress from one end of what I flippantly frame as the subjectivity-science
continuum (see Fig. 5.2) to the other. The ends of this stepwise progression could just as easily be transposed without any loss of meaning. In short, ordering is arbitrary.

![Diagram of diagnostic tools employed]

**Figure 5.2 Diagnostic tools employed**

Because of time constraints, most interviewees didn’t detail the entirety of their diagnostic procedures. As such, I’ve assembled tables which summarise much of the (often tangible) information shared by my informants. Each of the three “steps” will be represented by one or more quotes in order to give the reader a taste of the data.

The uppermost end of the continuum is best exemplified by a German sceptic who felt true NPD was rare enough to be subsumed under dissocial PD:

“I take the SCID-II, go the through the questions, asking them word-for-word, so two, three questions per criterion, and then I additionally blend in the general [PD] criteria. That means, concretely, does the criterion or its consequences cause self-distress? … Disorder comes only when they suffer directly due to consequences of fulfilling the criterion. … Or if someone were
legally entangled, they’d violate the law and receive a verdict. And then the criterion of laying out the red carpet, for example, I deserve special treatment, if they illegally pass on the shoulder and get cited by the police, and receive multiple citations because they feel entitled to do things others aren’t allowed to. And they would receive citations, then it would be a disordered presentation. If they don’t draw attention, if they forcibly overtake somebody and feel entitled, then they wouldn’t be disturbed. There’s the concrete answer. And any variable could discriminate, so to speak, yeah?” (DE-CP-7, 21.02.2014)

Of note here is the curious mixture of strict defence of both the official criteria and individual rights juxtaposed with the reference to the legal system. A classic ‘labelling’ theory interpretation would be that psychiatry is social control, judging morally rather than scientifically. I feel legal trouble is taken as an indicator, rather than an absolute symptom, of underlying illness. In other words, a boundary is erected between the moral and the psychotherapeutic. We can trace this back to Freud, which suggests again path dependency and the similarity of seemingly opposed therapeutic stances.

Different weight placed on different types of clinical evidence will be addressed latter, but for now suffice it to say that both TFP and DBT both fall in the middle range. A young German clinician who considered herself more of a researcher is illustrative:

“In the first session, one does not diagnose [NPD]. Basically I may sometimes have a gut feeling. But that can be wrong too, yeah? It can present differently, it doesn’t always have to be the same [NPD]. For that reason, I’d always, and I do this in my practice, draw on diagnostic instruments. … And then, so to speak, you should also consider informant ratings too, yeah? Because my assessment could also be off the mark. So it’s always very good if you ask the patient if they can invite a spouse or a friend along, and then you can use their testimony to verify the crucial criteria.” (DE-CP-1, 5.03.2014)
The same sort of scientific scepticism was however to be found in an American psychoanalyst: “I don’t usually diagnose a [PD] in one or two visits, but the things that might get me thinking in that direction are…” (US-PP-2, 9.05.2013).

Uncertainty of impressions is generally acknowledged by clinicians, at least those I interviewed. ST trainees, for instance, were cautioned, “Don’t jump to the conclusion just because you were feeling a little uncomfortable that this is a narcissist” (US-LCSW-1, 16.09.2013).

Specific feelings aroused in clinicians by their patients (countertransference) were raised only by psychodynamically-oriented practitioners. These detailed descriptions tended to come more from older, European informants.

<table>
<thead>
<tr>
<th>Potentially Diagnostic Reaction</th>
<th>GE</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling engulfed (vereinnahmt) or devoured (verschluckt)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Independent thought forbidden</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not allowed to say something different or oppositional (shräg)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Not allowed to cough, breathe, or possibly even move</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Boredom and emptiness</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Early fascination and excitement</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Feeling small, helpless, uncertain, potentially angry (Größenselbst)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Feeling the urge to help, devote oneself to patient (sich zuwenden, Größenklein, DE-P-4)</td>
<td>1</td>
<td></td>
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<tr>
<td>Feeling the urge to dominate and devalue patient (DE-P-11, 5.03.2014)</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Not being heard or experienced as &quot;other&quot;</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Oscillating feelings of importance and self-criticism</td>
<td>1</td>
<td></td>
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<tr>
<td>Feel charmed, won over</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Feel idealised but also subtly devalued (Minigrenzverletzungen, DE-CP-4, 12.03.2014)</td>
<td>1</td>
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<tr>
<td>Need to be on the ball, a 'champion' (DE-P-12, 17.02.2014)</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Proud to have such a patient</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Both younger participants (one American, one European) were active researchers, which argues against a purely “scientistic” interpretation. More probably these senior practitioners felt more comfortable endorsing such a theory-laden, subjective method, as they had nothing left to prove.

<table>
<thead>
<tr>
<th>Indicator related to grandiosity or vulnerability</th>
<th>GE</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vacillation between grandiosity and worthlessness/vulnerability; rapidly shifting moods.</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Haughty.</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Grandiose fantasies, including those believed to reflect reality (CH-P-2, DE-P-1), and those masked by self-denigration or negative in valence (A-P-2, DE-CP-3, DE-P-4). In extreme cases, &quot;to deny yourself the actual experience to maintain that fantasied image&quot; (US-CP-9, 6.06.2013) or suicide as &quot;grandiose fantasies… that they'd rather sink themselves than allow themselves to be humiliated&quot; (DE-P-8, 6.05.2014).</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Black and white thinking, e.g. cast things in terms of power (strong vs. weak) or worth (valuable vs. worthless), and/or have a one-sided perception of conflict (either victor/vanquished).</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Disruption in or disturbed sense of self, labile self-esteem, described by one informant (DE-P-6) as a &quot;self-esteem deficit but not to the extent of a full-on borderline personality organisation&quot; (21.02.2014). Pathologically grandiose self, &quot;everything that has a negative valence is projected, is perceived as other&quot; (US-P-1, 22.05.2014).</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Know-it-all or know more than therapist (Größenselbst, DE-P-4, 4.02.2014), sometimes manifests as &quot;they absolutely need the feeling that everything that comes from the analyst, that they already knew it beforehand.&quot; (DE-P-12, 17.02.2014).</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

27 Here and in all subsequent tables, GE is shorthand for Germanophone Europe and NA for North America.
Easily irritable; high sensitivity to criticism, conflict, advice, or disappointment; easily humiliated/slighted or discouraged (DE-P-8, US-PP-3); may have early difficulties with humour (CH-P-2); deprivation and anger may play a role in irritability (DE-P-8, DE-P-10, US-PP-2) where the anger is hidden or shown in sulking or brooding (closet narcissists, US-PP-3, 9.05.2013); may respond to disappointments in extreme ways (CA-CSW-1, US-PP-3).

<table>
<thead>
<tr>
<th>Description</th>
<th>Source/Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Focused on what they don't want to have&quot; (US-CP-5, 15.05.2014); denial of own neediness or helplessness, e.g. &quot;very allergic to coming in contact with depressive content&quot; (DE-P-12, 17.02.2014) or avoiding dependence on others (at the edge of antisocial, DE-CP-4, DE-P-12); projection of shame (US-PP-2).</td>
<td>2 2</td>
</tr>
<tr>
<td>&quot;Kind of an emotional detachment&quot; (US-PP-1, 23.05.2013); &quot;missing responsivity [and] emotional resonance&quot; (DE-P-12, 17.02.2014); &quot;some lack of spontaneity&quot; (US-PP-2, 17.05.2013).</td>
<td>2 2</td>
</tr>
<tr>
<td>Envy, unconscious according to DE-P-12 (17.02.2014).</td>
<td>2 1</td>
</tr>
<tr>
<td>&quot;Chronic feelings of emptiness and boredom&quot; (US-PP-3, 25.06.2013) or life's insignificance (as opposed to melancholic depression, US-CP-1, 6.06.2013); dysphoria in thin-skinned narcissists (US-P-1, 22.05.2014; also US-PP-3).</td>
<td>1 4</td>
</tr>
<tr>
<td>Entitlement, e.g. to rapid advancement in work or school (sometimes causing failure due to own impatience, US-P-3, 25.06.2013), to admiration (CA-P-1, DE-P-3), or to special treatment (e.g. coming late &amp; expecting full session, not following therapist's SOP, payment issues, special times/parking spot), generally being above rules and boundaries, or having an expansive/enveloping (Übergriffig, DE-P-2, 20.12.2013) presence (also DE-P-10). May be expressed in a lack of gratitude at the session's end (CH-P-2, 7.02.2014).</td>
<td>5 8</td>
</tr>
<tr>
<td>&quot;Excessive motivation&quot; (US-CP-9, 6.06.2013) for self-enhancement, i.e. admiration and recognition.</td>
<td>3 2</td>
</tr>
<tr>
<td>&quot;Effort to regulate self-esteem as best as possible in the context of their symptoms and behaviours&quot; (DE-P-6, 21.02.2014), e.g. &quot;punishing the self for not having the grandiose achievement&quot; (US-CP-1, 6.06.2013) or compensating for perceived deficits with achievement (closet, US-PP-3, 9.05.2013).</td>
<td>1 2</td>
</tr>
<tr>
<td>Rejecting, defensive (e.g. don't want to admit weaknesses or faults, DE-P-4, 4.02.2014), closet narcissists assume others will put them down and may hold secret contempt for others (US-PP-3, 9.05.2013).</td>
<td>2 1</td>
</tr>
<tr>
<td>&quot;The gap [between an extremely... exaggerated expectation of accomplishment and the actual state] is huge and insurmountable&quot; (&quot;thin-skinned narcissists,&quot; US-P-1, 22.05.2014).</td>
<td>1 2</td>
</tr>
</tbody>
</table>
Lack of "internal compass", adapt to what they perceive as other's wants (US-PP-1, 23.05.2013) or have 'infantile' aspirations (US-P-3, 25.06.2013), may 'show an incapacity for higher-level values' (US-P-3).

Table 5.2 Symptoms related to grandiosity and vulnerability

<table>
<thead>
<tr>
<th>Interpersonal Indicators</th>
<th>GE</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loneliness; empty, shallow, or unfulfilling relationships.</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Difficulties with trust or entering relationships. They may &quot;provide kind of a two-dimensional picture of other people&quot; (CA-P-1, 21.08.2013), which some respondents called impoverished representations of others (US-CP-6). In extreme cases, closet narcissists may &quot;avoid social situations because they're always afraid they're going to be unmasked&quot; (US-PP-3, 9.05.2013; DE-P-1).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attempt to control their surroundings to self-regulate, e.g. by using relationships to obtain narcissistic supply (either through mirroring or association with someone 'great').</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Patient's relationship choices, e.g. CSW over P as therapist (US-PP-2), or a &quot;complementary narcissist&quot; as romantic partner (grandiose seeks vulnerable, and vice versa, DE-CP-2).</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Impaired empathy, e.g. for alter in conflict-talk (DE-CP-1, 5.03.2014). Also described difficulty with &quot;theory of mind&quot; (taking the role of the other, CH-P-1, 22.01.2014, speaking of &quot;narcissistic difficulties in the broader sense&quot;).</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>&quot;Dismissive and avoidant&quot; (US-CP-5, 15.05.2014) attachment style. Informally described as more &quot;relationship-phobic&quot; than borderline patients (CH-P-1, 22.01.2014).</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Frequently defends self in speech, &quot;inability to carry out effective self-criticism&quot; (CA-P-1, 21.08.2013). Don't see or acknowledge own contribution to difficulties, &quot;an inability to feel guilty&quot; in genuine NPD (DE-P-12, 17.02.2014). Don't come with presenting problems as other patients do, but tend to discuss themselves (DE-CP-6, 25.02.2014).</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

28 «I am comfortable without close emotional relationships. It is very important to me to feel independent and self-sufficient. I prefer not to depend on others or have others depend on me.

If you agreed with these statements (…), you may have a ‘dismissing’ state of mind with regards to attachment” (Wilkins, Shemmings, and Shemmings 2015:20).
Destructive or hostile in their relationship to others, e.g. when perceived as blocking them from just desserts (CA-P-1). Can manifest in "a tendency to trick and cheat, so to falsify and lie also," and involve mental or literal robbery in genuine NPD (DE-P-12, 17.02.2014). Subtler signs include using the wrong (e.g. first, US-CP-11) name or being 'unable' to remember clinician's name (DE-P-12).

Idealise and devalue others. Disappointment when idealised other proves ordinary (US-PP-3; DE-P-1, 11.02.2014 sees this as occurring in vulnerable presentations).

Problematic therapy relationship: May compete with therapist (CH-P-1; DE-PP-1), or consistently criticise and/or devalue treatment/treater (including correcting therapist and placing them on the defensive, US-LCSW-1, 16.09.2013). Grandiose presentations alternate between "seduction" (Verführung) and distrust of therapist (DE-CP-2, 8.01.2014).

Self-extolling speech, or "strikingly self-occupied" (US-CP-5, 15.05.2014).

Other communication difficulties: Talking as if to an audience (DE-PP-8, US-PP-3), studying the analyst and speaking 'psychoanalyse' as well as "talk[ing] an awful lot about 'meaningful' stories, in order not to feel them,' and they seduce the analyt"(DE-PP-12). Suicide "to communicate that you're not doing enough for me" (US-CP-1, 6.06.2013). "[T]hey want you to shut up and mirror their good qualities" (US-PP-3, 9.05.2013).

All or most "instrumental action and interpersonal relationships are related to self-esteem regulation, with proof of one's own worth compared to other people" (DE-P-5, 28.02.2014). More specifically, it can be "someone who needs to have this operation going on where he's at the centre of attention, otherwise he feels almost like he doesn't exist, in a way" (CA-CSW-1, 6.09.2013) or feeling "like each relationship is a test of [their] worth" (US-PP-3, 9.05.2013).

"Overly concerned" (US-LCSW-1, 16.09.2013) with impressing therapist, or drawing their attention or recognition (raumgreifend, DE-P-10, 21.03.2014).

<table>
<thead>
<tr>
<th>Table 5.3 Symptoms related to interpersonal situations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Destructive or hostile in their relationship to others, e.g. when perceived as blocking them from just desserts (CA-P-1). Can manifest in &quot;a tendency to trick and cheat, so to falsify and lie also,&quot; and involve mental or literal robbery in genuine NPD (DE-P-12, 17.02.2014). Subtler signs include using the wrong (e.g. first, US-CP-11) name or being 'unable' to remember clinician's name (DE-P-12).</td>
</tr>
<tr>
<td>Idealise and devalue others. Disappointment when idealised other proves ordinary (US-PP-3; DE-P-1, 11.02.2014 sees this as occurring in vulnerable presentations).</td>
</tr>
<tr>
<td>Problematic therapy relationship: May compete with therapist (CH-P-1; DE-PP-1), or consistently criticise and/or devalue treatment/treater (including correcting therapist and placing them on the defensive, US-LCSW-1, 16.09.2013). Grandiose presentations alternate between &quot;seduction&quot; (Verführung) and distrust of therapist (DE-CP-2, 8.01.2014).</td>
</tr>
<tr>
<td>Self-extolling speech, or &quot;strikingly self-occupied&quot; (US-CP-5, 15.05.2014).</td>
</tr>
<tr>
<td>Other communication difficulties: Talking as if to an audience (DE-PP-8, US-PP-3), studying the analyst and speaking 'psychoanalyse' as well as &quot;talk[ing] an awful lot about 'meaningful' stories, in order not to feel them,' and they seduce the analyt&quot;(DE-PP-12). Suicide &quot;to communicate that you're not doing enough for me&quot; (US-CP-1, 6.06.2013). &quot;[T]hey want you to shut up and mirror their good qualities&quot; (US-PP-3, 9.05.2013).</td>
</tr>
<tr>
<td>All or most &quot;instrumental action and interpersonal relationships are related to self-esteem regulation, with proof of one's own worth compared to other people&quot; (DE-P-5, 28.02.2014). More specifically, it can be &quot;someone who needs to have this operation going on where he's at the centre of attention, otherwise he feels almost like he doesn't exist, in a way&quot; (CA-CSW-1, 6.09.2013) or feeling &quot;like each relationship is a test of [their] worth&quot; (US-PP-3, 9.05.2013).</td>
</tr>
<tr>
<td>&quot;Overly concerned&quot; (US-LCSW-1, 16.09.2013) with impressing therapist, or drawing their attention or recognition (raumgreifend, DE-P-10, 21.03.2014).</td>
</tr>
</tbody>
</table>

More eye-catching quotes from the subjective side typically came from psychoanalytic practitioners. One clinician (DE-P-12) showed his characteristic bombast and humour while describing how he recognised pathological narcissism:

“… it comes down to how benign or malignant is this narcissism."
... The patient, for example, sits down right where you’re sitting, and says, ‘Oh, God, I forgot your name. What’s your name again?’, even though we just telephoned, oh yeah, and my name’s on the sign out there. That would be suspicious, for instance.”

(17.02.2014)

Ordinary incivility, a violation of the rules of acquaintanceship (Goffman 1963a:120), serve as an early warning system. The next step is more theoretical, but still relates to the ritual regard we show our fellow man: “Also very suspicious is when all human objects – in our unsightly language – don’t have a face, rather they just somehow drift and exist, but like coordinates and not like real people with depth” (17.02.2014).

His first reference to countertransference descends into the realm of the technical:

“…[M]y manifest, evoked countertransference will carry a lot of weight. For example, if early in the session I get the feeling I’ve got to be really on the ball, give especially clever interpretations, then I already know that the patient is a ‘champion’ and the analyst has got to be a ‘champion’ too. … also, if I get the feeling somebody’s engaging in ‘corruption of meaning’, as I called it in English. People talk an awful lot about ‘meaningful’ stories, ‘in order not to feel them’, and they seduce the analyst. What, I can’t remember [the name], ‘Dictionary of Kleinian Thought’, the Englishman [R.D. Hinshelwood?], [called] ‘the transference on the mind of the analyst.’”

(17.02.2014)

I pause here midstream because we see the psychoanalyst acting as a microsociologist, following situational cues and the flow of both interactional content and affect (cf. Luhrmann 2000:192; Young 1995:145-146). Though the methods (astute attention to interactional detail with or without a structured interview) and some of the exact symptoms focused on differ, there is more alike than not. It is a narcissism of minor differences across these different theoretical traditions.
Finally, we see an attempt at role reversal in that the patient observes the analyst in this precise, ethnological manner, and cynically (in Goffman’s [1973] sense) uses ‘trade talk’. In general, the patient could be taken as attempting to seize “directive dominance” (97-100), if only symbolically:

“These patients often aren’t bothered about getting helpful commentary already in the first session, but you notice they’re tracking exactly how the analyst thinks, ‘in order to get hold of his mind.’ And frequently pseudo-analytic, ‘Psychoanalyse’ comes up with these patients. … But ‘the secret behind is’ they have an absolute need to feel that they already knew in advance everything the analyst offers them. … You notice that in the first session.”

(DE-P-12, 17.02.2014)

Less extreme but still notable is a Kleinian’s (DE-P-8, 6.05.2014) clarification: “I’d really zero in on the way they related to me, not so much on the content of someone’s speech.”

We are reminded that the practitioner’s model determines how the relationship is construed already in assessment, and that psychiatric professionals must be awake to their interlocutors.

In the middle range, however, theories can hold hands and happily coexist. A then-training practitioner described a case where he had conducted neuropsychological testing:

“[Patient] came in saying [they have] processing problems, problems understanding people. [Their] therapist said, ‘It’s your narcissism that makes you not listen to people,’ (informant chuckles) and so we needed to distinguish this. I gave him a battery of tests, both neuropsychologically oriented as well as [the Minnesota Multiphasic Personality Inventory], which was a nice way to get at [their] kind of narcissism. I also gave [them] a few other things. And the basic story is that [they do] have a processing problem and [they] also [have] a narcissistic problem, and they
interact and go together. So I’m going to describe to [them] how these two pieces can impact with each other. Part of it is [they have] trouble organising things, and part of it is that [they don’t] feel like [they] should have to when [they’re] listening to people in authority.”

This quote represents potentially disconfirming evidence, as we see boundaries between two forms of gaze blur. If conceptualisation isn’t as restrictive as some portend or perceive, however, the possibility remains open that similar understandings are lost in translation. People may just be talking past one another (cf. Kuhn 1996:149-151), deeper likenesses buried by language. Models then serve to make the individual practitioner’s life easier, but can simultaneously overstate differences. Similarly, there is only so much time: it needn’t be theoretical traditions seek to segregate themselves, but that people prioritise texts and conferences from their method. Solidarity is greater here because everyone speaks the same language.

The science-subjectivity schema is underlain, I argue, by an eye for the context of events, symptoms, episodes. Here the microsociology stretches out of the consulting room and back into the pre-patient’s environment. Three informants of very different pedigrees referred to the importance of such situational signs in some way. A French-trained psychoanalyst (DE-P-7, 13.02.2014) spoke of resources: “You can recognise it according to specific symptoms, but I wouldn’t reduce that to the diagnosis, rather I’d look where there are too many stressors and where are there too few resources.” He went on to stress that one can’t simply take diagnoses for granted:

“Take crimes of passion, for example, those are to some extent totally normal people who enter into highly aggressive situations. In that instance, massive pathological narcissism exists where there’s a large measure of woundedness, that interaction could lead
to some heinous offences. That doesn’t mean they’re a pathological narcissist, just that the situation loaded them up in that way.”

We return to Goffmanian (1967:3) terrain: “Not, then, men and their moments. Rather moments and their men.”

Both an American interpersonal CP and a difficult-to-categorise German psychiatrist pushed situational cues to the fore. The German (DE-P-1, 11.02.2014) suggested that both “schizoid… or schizotypal people” and narcissists have problems with interpersonal distance, but stressed that “grandiosity and entitlement belong to narcissism by definition.” Although he neither seemed (nor professed to be) psychoanalytic, we see here analytic thought in action. His description of how quickly one can recognise narcissism further bolsters this impression: “Naturally there are narcissists whom you spot in the first session, there are others where you only notice after one, two, three months that they’re suffering from a narcissistic disturbance.” The idea of ‘closeted’ or vulnerable narcissism seems implicit in this response.

A more biologically rooted situational approach can be found in the interpersonal psychotherapist’s description of a structured diagnostic interview. This situational understanding of psychiatric illness led her to dismiss the notion that there are two discrete subtypes of narcissist. It is all a question of which response pattern is activated by the immediate environmental stimuli:

“I don’t see one type of narcissist versus another type of narcissist. I would see both of those. Maybe one is more predominant in a given person, but it’s all triggered by current states that may activate those old patterns. So I look for the current crisis and the
response to it, how that derives from early learning with attachment figures, and what the expectations are, where those came from, and put that together and get this interpersonal summary.”
(US-CP-8, 20.08.2013)

We find here disconfirming evidence for Mirowsky and Ross’ (1989:17) baseless assertion that “[d]iagnosis is a two-part process of gathering information and then ignoring most of it.” What happens is not “ignoring” but theory-driven data sifting. The clinician’s concepts and experience give clues as to where to look and what might be done. Essentially what is done is the extraction of a pattern, seeing a signal amongst the noise.

She later elaborated how models help guide the clinician’s hand:

“I think assessment should start with the person’s presenting symptoms, and it should then learn about the context in which those are expressed. It should then have a concept, a testable/rejectable theory of how come now, and what links this current exacerbation of personality patterns or anxiety and anger, depression –narcissists can have them all – and where they come from and what’s it for, what is it trying to do. There my theory is that they are trying to get the approval and love and affirmation of the internalised representation of the parent who’s operative now. That, of course, is theory-directed. That’s not typically American now.”
(20.08.2013)

While it draws on the same ritual apparatus as Goffman’s etiquette manual authors, psychiatry doesn’t necessarily use this to ‘moralise.’ The goal is understanding, which draws on social gaffes because, for the majority of humans, our environment consists largely of other people. Breaches of etiquette, to use an extreme formulation, matter because they are moments where a person’s ability to navigate situations has gone wrong. It isn’t immorality which draws a psychotherapist’s eye, but the mismatch in definitions of the situation. The goal in this particular instance is a restoration of adaptive functioning, which is situationally flexible. Other therapies
(e.g. Sachse et al. 2011:89) similarly bracket questions of morality. Symptoms and personality are intertwined, and thus both need to be assessed.

Another cross-theoretical and cross-scientific practice, then, is the use of what a psychoanalyst (DE-P-12, 17.02.2014) called symptomatic and structural diagnoses. While he relied on countertransference and other “soft signs,” two other very different practitioners endorsed this approach, albeit it in different terms and with different methods. An integrative American CP mentioned a variety of possible instruments he might apply, depending on whether there seemed to be a need to explore psychoticism, say:

“I think the Big Five\textsuperscript{29} more or less organises the important [stuff], plus maybe intelligence, plus cognitive variables, they become important, attention, memory, that kind of stuff. That's sort of a basic framework for getting to know what the person's like. … Now, knowing what a person's like is going to tell us a lot about risk for certain symptoms. … So the next question I have is what specific problems are, and I like to be able to develop, if possible, a functional analysis of those problems.” (US-CP-4, 21.04.2013)

An assessment specialist (US-CP-7, 2.03.2015, email) gave this telling definition of assessment: “Assessment is a broader term than diagnosis, encompassing additional non-diagnostic but psychologically important information (e.g., personality, intelligence, etc.).” Regardless of whether they describe personality in terms of traits, maturity and defence mechanisms, schemas, or response patterns, my respondents weren’t just idly ticking off a checklist of symptoms. Context matters, at least for PDs. Conceptualisation helps the practitioner separate out meaningful slices of interaction (e.g. paralinguistic cues or the how of the interaction in the Kleinian’s case, [DE-P-8, 6.05.2014]).

\textsuperscript{29}Five higher-order traits often describe personality: openness, conscientiousness, extraversion, agreeableness, and neuroticism.
But once we’ve used theory to indicate what symptoms are activated when, and
“what the person’s like” (US-CP-4, 21.04.2013), how do we decide what illness it is?
How does an approach help clinicians to distinguish or discriminate disorders?
Conceptualisation, I argue, gives the clinician a stock of knowledge against which to
compare individual patients, and so allows effective sorting.

(II) Distinction: Comorbidity, or “the only place you find a pure
narcissist is in the pages of DSM-5”

As the above informant (US-CP-3, 2.08.2013) indicates, there is a large comorbidity
problem with PDs. He further elaborates:

“It appears so clear in DSM-5, as it was in IV-TR and previous,
‘Here’s the narcissist.’ In the real world, I think we’re better off, as
I said, arousal-spectrum disorder with elements of, this, this, and
this, as opposed to NOS [not otherwise specified].”
(2.08.2013)

Several NASSPD presentations across my years of attendance suggested that PD
NOS or “Axis II – deferred” are the PD diagnoses most often found in charts. The
informant implies here that one reason this is done is to avoid drawing artificial
distinctions. Whooley (2010:461) also indicates that this can be done also as part of
an effort to “give vague diagnoses so as not to invite outside influence on the
treatment or any stigma on the patient.” We see here hints of the dispersion and
direction stages. Another clinician pointed out a specific area where symptom-based
diagnosis proved problematic: Addicts may not be “NPD in the narrow sense” but
fall under an umbrella term, “narcissistic problems” (CH-P-2, 7.02.2014). What the
practitioner does is to frame these symptoms (say manipulation) in the broader
physiological (dependence) and social context of the patient’s life.

A German clinician had more outwardly scientific reasons for doubting that we could distinguish PDs. I asked him how we can differentiate borderline, which also has unstable self-esteem, and histrionic, which can also present with grandiosity:

“All at all. (Both laugh.) So you can do interviews, you can do SCID-II and answer the questions and then you’d establish that there’s a large overlap of diagnoses present. Research shows that. Evaluation of scientific findings (*Forschungsergebnisse*) shows that you can’t cleanly partition them from one another. The overlap is too large, and there remains a general factor that they call [PD] (CFD laughs), but it doesn’t let itself be precisely differentiated. And that’s a stress, it’s more of a disorder of emotional regulation, [and] impulsivity with borderline that’s more pronounced. And the attention-seeking behaviour in histrionic [PD], and self-esteem issues. It’s more how pronounced something is. But the underlying disturbance (*Grundproblematik*), in my opinion, isn’t different. I can’t testify that these are different *illnesses*, that’s not how it is.”

(DE-P-9, 12.03.2014)

He references the scientific literature, which is then explained in theoretical terms.

Though the answer is abstract, we can see that there are two rapid, relevant comparisons being made by the clinician in the moment. The pre-patient’s various problems in living are stacked and weighed against one another, creating an intrapersonal reference. But at the same time, the person as a whole is weighed against others, as represented by the practitioner’s stock of knowledge. Patients can be aware of this: “The social phobia support group I attended provided a list of physicians who specialize in the treatment of social phobia. These physicians ‘see’ social phobia where others might see neurosis” (Lloyd 2008:287n13).

While some informants referred to specific symptoms or aetiologies in the context of differential diagnosis (*DDX*), the trend was to refer more to systems of thought (ICD,
DSM, Kernberg’s model, the OPD, and others). A conceptual system provides the clinician a greater degree of security in making these types of comparisons. I asked a German psychiatrist what his procedure for DDX was:

“First, I try and differentiate whether it’s a conflictual or structural disturbance. Does it always recur in life at certain conflict points, or is it a basal regulatory disorder? Then I look at how the person’s functioning, usually with OPD – so, self-/object-relations, communication, capacity for attachment, attachment history. Then I check out the central themes in their professional life with the appropriate relationship with, origin, [and] handling of the illness.”

(DE-P-5, 28.02.2014)

He stresses the intrapersonal aspects of the comparison, but note how the system structures the data collection and comparison. An unordered biography is just a jumble of facts, but theory enables practitioners to make treatment-relevant decisions already at this early stage: “a basal regulatory disorder” calls for different treatment than would a “conflictual… disturbance”, after all.

This particular practitioner referred to two further classificatory schemes:

“I find, so to speak, that the most valid distinction is between the expressive-expansive [PDs] and then the more passive [PDs]. But if we’re talking specifically about narcissism, it’s naturally tightly bound to the borderline structure. There’s a big overlap, and they’re often hard to separate out.”

(DE-P-5, 28.02.2014)

We see, however, that the references are implicit. Kernberg treats borderline as a level of personality development (borderline personality organisation30), as does this clinician. The split between “expressive-expansive” and “passive” seems to draw upon Millon’s classificatory work on PDs. A similarly subtle reference to Millon springs forth from a COP clinician:

“[F]irst off we distinguish two large groups – proximity- and

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30 OPD doesn’t use Kernberg’s terminology, but their levels of integration (high, moderate, low, disintegrated) roughly equate with his (neurotic, high borderline, low borderline, psychotic).
distance-disturbance. So a proximity disturbance means the clients enter into relationships, they’re open to relationships. … So we quickly build up trust, at some point they also begin to share personally relevant material. And the distance-disturbances are those who are very distrustful, the ones who very slowly enter a relationship. And these are, for example, paranoid, obsessive-compulsive, schizoid, and passive-aggressive [PDs]. There you see they’re cautious, they don’t say much at all, they also take a long time to develop trust. So in therapy it takes a long while before you get the feeling the clients are sharing any meaningful information.”

(Preliminary data are then compared against official and/or experiential frameworks to determine what diagnosis seems most appropriate for the patient. Theory here orders experience, and shows the clinician what they ought to be looking for. But does it also dictate how they relate to the pre-patient after a hypothesis has been made?

(III) Discussion: ‘Ok, I’ve got this thing, so where’s the pill for that?’

In describing a supervised case where the patient prematurely terminated, an American practitioner (US-CP-4, 3.05.2013) offered the above hypothetical reaction to a poorly delivered diagnosis. His comment indicates that diagnosis is more than identifying an illness based on its presentation. After diagnosis is ‘achieved,’ how do psychiatric professionals proceed? Rosenberg (2002:255) indicates that “[d]iagnosis remains a ritual of disclosure: a curtain is pulled aside, and uncertainty is replaced – for better or for worse – by a structured narrative.” As elsewhere, one’s conceptualisation serves as a guide for how to navigate this particular interaction with the patient.

Most of the professionals I interviewed engaged in a process one informant called
translation, a process Koehne and colleagues (2012:50-1) call “reframing”. While the practice is widespread (ranging from TFP to DBT practitioners), it could take different forms in the consulting room and serve varying purposes for different clinicians. Two more exceptional cases were psychoanalysts. One American framed it as a service available on-demand:

“I don't usually get into labelling people in any event, so it doesn't come up that I have to make a distinction for them unless they're insisting on knowing what their diagnosis is or how I think about their diagnosis. And I use descriptive language rather than labels when I'm working with somebody so if somebody comes in and I see them as really much more borderline-y in their presentation and they may have a lot of narcissistic features, they might have grandiosity or they might have a strong inclination to feel entitled, but I don't see their structure as primarily narcissistic.”

(US-PP-2, 9.05.2013)

US-PP-3 (23.05.2013) reaffirmed his sentiments, and went still further, saying, “But generally people don't insist on having those sorts of labels once they hear how I think about it.”

A German psychiatrist and psychoanalyst, however, mentioned the need to explain what a diagnosis means (both definitionally and operationally), before going on to elaborate that diagnosis enabled clinicians to have a crude understanding of what the other clinician meant:

“The intent or point and purpose (Sinn und Zweck) could be to simplify communication about the patient. So when you say he and she have this and that shoe size, you don’t have to describe it – the foot is as big as the forearm of an average adult human. You say size 46 or something. It’s sort of like that here too: you say this and this diagnosis. But ultimately that’s an extreme data reduction, and even when you count up the possible combinations in borderline or somewhere else, you meet five criteria, three criteria, and eight criteria, you can’t do the maths. It’s a crutch (Notbehilf), I think, and you shouldn’t believe in illusory exactitudes (Scheingenaigkeiten). But whatever my thoughts on someone, I
discuss it with them.”

What this quote suggests is that the diagnosis itself has a bureaucratic purpose, and that – at least for this individual – his thoughts don’t mesh precisely with the official label. Another key point is that the patient is given more than just a name and rushed out the door. The paternalistic model of physician-patient relations doesn’t hold here. He is perhaps unique amongst psychoanalysts in his willingness to discuss the diagnosis with patients.

Diagnoses serve as *a lingua franca*, allowing clinicians of different theoretical orientations (thus, the schools themselves) to understand one another – albeit in a somewhat impoverished way. One practitioner (US-CP-3, 2.08.2013) explained that DSM diagnoses were not “pigeon-holing” patients, but rather: “We're developing a language that I can talk to you about, you can talk to me, so that if you say narcissistic personality, I have an *idea* what you're talking about.”

For the bulk of translation, the labour is transforming technical terminology into something comprehensible and even acceptable to the patient. One clinician underscored the skill involved:

> “You have to be very nuanced in your feedback. And I think a lot of clinicians decide essentially not to give that kind of feedback, because they're not trained well enough to know how to do it. Or they feel like it will hurt the patient's feelings or cause some sort of rift. But the problem is not the information itself, it's how the information is given and how that's processed between patient and the therapist. And so I think that there's just low rates of diagnosis as an artefact of that. Not that it really is a low base rate disorder.”

(US-CP-6, 7.06.2013)

Avoiding interactional unease between therapist and client, he implies, can
concatenate and create systemic errors.

Beyond showing care, rendering a psychiatric diagnosis comprehensible can enlist the patient as an active collaborator rather than as the passive recipient of ‘labelling theory.’ A practitioner whose technique integrated many different therapeutic approaches described his early experiences in assessment as follows:

“So you collect all these data but you try to partner with the patient around understanding what the data mean. So you say things like, 'Sometimes the data are wrong, sometimes they're right, the goal for us is to figure out what they mean as opposed to some of the diagnosis per se.’ At the end of the day, sometimes diagnosis really captures what's going on with a patient, and that's really useful because it tells us exactly what kind of treatment we think is going to be most helpful, and sometimes it just is sort of a summary statement that describes something that's really more complicated.”

(US-CP-4)

While the diagnosis itself can be variable in its worth, assessment offers an opportunity for alliance-building. He suggests that this set-up makes the ‘reveal’ less painful:

“And together the patient and the therapist have to figure that out, right? So that's kind of the way I pitch it. It makes it easier to say, ‘In the book, all this stuff that we've been talking about, is summarised by this term narcissistic.’ And it takes the edge off a little bit, right? Cos otherwise it sounds kind of nasty, it's something that you really don't want to be. But if the person's already on board with the formulation, then it gets a little bit easier for them to tolerate that term, you know?”

(US-CP-4)

Beyond translation, there is also a contextualisation of the symptoms or the disorder in a way which normalises the patient’s behaviour. It extends the therapist’s tools to the patient, giving them a less stigmatising means of organising their biography and illness career:

“…I think you can try to frame the personality problem in terms of an effort to adapt to an undesirable set of circumstances. … So if
we can talk about that kind of problem with somebody that way, it doesn't feel like you're labelling somebody pejoratively, but it feels like you understand that what they're trying to do comes from an honest place, but they're just having a hard time doing it.”  
(US-CP-4)

Data, for instance, collected in the various forms, tests, and interviews the clinician used become a shared resource rather than a secret known only to the expert:

“And use as much test data as possible to try to help a person become interested in themselves. So that maybe instead of you interpreting data, maybe they can, that would be the ideal. So you say like, ‘It seems like your self-esteem really goes up and down a lot, what do you make of that?’ If they can sort of say back, ‘When people are paying a lot of attention to me and I get what I want, then I feel good about myself. But when I feel lonely, like people don't care about me, that's when I feel bad about myself.’ And then you don't have to say it to them, so it's not like you're delivering a diagnosis, it's like they're learning something about themselves, which happens to map onto a label in the DSM.”  
(US-CP-4, 3.05.2013)

We see a strategic backgrounding of formal diagnosis in favour of the patient’s own words, if at all possible. The patient’s own curiosity helps to build a therapeutic alliance, because the clinician is not seen as being authoritative and distant31, but comes to be a “helpful other.”

One TFP practitioner took this a step further and extended the patient’s awareness outside the pathological:

“So then I translate it for the patient, but … recently a narcissistic patient of mine came and brought a description of NPD from the Internet and said, (informant slaps the table with an open hand) ‘This is me.’ And I said, ‘Yeah, that’s right, that’s you, but maybe you’re not paying your strengths enough attention. That’s a strong description of nothing but the flaws, but,’ and I’d always say this with [NPD], ‘but you’ve also got certain strengths. You generate new ideas, you can move a group to action, you don’t sweat the small stuff but rather you see the big picture,’ …”

31 Several clinicians stressed the need for therapists to be warm, but also dominant.
The patient is not seen as merely defective or somehow deficient, but has their positive attributes taken into account and even reinforced.

Informants from the two poles of the therapeutic spectrum both pointed to the revelatory and levelling effects this approach can have. A DBT clinician (US-CP-10, 15.08.2013) pointed out how sharing information generates solidarity:

“First of all, I think that helps people feel like they’ve been a partner in discussing this with you, and you’re not just telling them something. The second thing – and I don’t have data on this, this is just what I think just based on my experience doing this – I think that people appreciate it when you as a clinician show them the DSM and then you’re like, ‘Let’s go through this together.’”

When questioned about the contracting phase, the same practitioner described therapy as “usually… kind of mysterious.” Our aforementioned lingua franca psychiatrist (DE-P-3, 13.01.2014) used similar language (Geheimwissenschaft) without prompting: “Of course you share [the diagnosis]. Therapeutic knowledge isn’t a state secret…”

DSM is here a prop, but rather than being something which differentiates, it unites. Having access to the document itself gives patients a greater sense of understanding, and possibly control. The interpersonal comparison of the patient to a body of knowledge is incarnated in as they participate in its construction and evaluation:

“I think it demystifies that whole diagnostic process, and again, it makes you more of a team. It doesn’t put you on this [pedestal] like, ‘I’m this person who knows all this stuff and you don’t know anything.’ And I’m always accepting. If someone says, ‘No, I don’t think that sounds like me,’ I’m always pretty accepting of that. I always say, ‘Well, you know yourself better than I know you.’ (She laughs.) So I always just say, ‘Are there any examples
of times where you’ve been like this or there’s really none?’
Usually people are pretty willing to discuss. So that’s the third
thing: I’m always accepting of it. When someone rejects feedback,
I always am pretty accepting of that and find another way to
discuss it.”

Status differentials, towards which narcissists are very sensitive, are thus smoothed.
Translation gives the patient insight into the therapeutic method, or at least offers a
shared language for its discussion (e.g. Rafaeli et al. 2011:75). Technical jargon and
its translation provide opportunities for both relating and distancing the patient from
what might be felt as integral aspects of the self.

Translation serves as a means of role induction. A psychiatrist using ST described
the relationship between assessment and treatment as follows:

“As a rule, my patients and I discuss what schemas, so I go through
the mode model with them so they can name each of them
themselves – my arrogant side, my cautious side, my irritated side,
my traumatised side, my overcompensated side, and then finally we
work together with whatever modes – in [ST] terms – they present,
what schemas feed them, and we also thoroughly review the
therapy goals.”

By linking the patient’s words with the model’s dialect, collaboration is fostered and
a shared language for discussing difficulties in living established. I speculate that
this common tongue derives some strength from the association of science and the
therapeutic approach. The theory is internalised, in the sense that it is made the
property of the patient as well as the therapist. Rosenberg (2002:241) partially
confirms this view, stating that “[a] time- and place-specific repertoire of such
agreed-upon disease categories has, in fact, always linked laypersons and medical
practitioners and thus served to legitimate and explain the physician’s status and
healing practice.”
Some practitioners stood out because of a psychodynamic scepticism. In response to a direct query about how they dealt with diagnosis and whether they shared it, a “classical Freudian psychoanalyst” answered:

“I try and analyse the need of the patient for a diagnosis. Usually it’s a need for, the patients say diagnosis, but unconsciously they’re asking, ‘Tell me who I am.’ And as soon as they comprehend that wish, they also understand that I can’t tell them that. Because everyone has to somehow find out on their own who they are, or decipher it from others’ reactions as a child.” (DE-CP-5, 4.03.2014)

A clinical psychologist taking a more contemporary psychoanalytic approach (US-CP-5, 19.05.2014) echoed this sentiment. What we see here is an understanding of diagnosis compatible with the goals of classic psychoanalysis: it is at most a theory of the patient, but this cannot simply be given to the patient. Insight must come from within.

An American psychoanalyst regarded sharing the diagnosis or not as a treatment decision:

“A discussion of diagnoses is not something I use therapeutically. When I first see patients in general, especially if they’re using insurance, you have to have a diagnosis to get the insurance, so I talk with them about that because I’m not going to give insurance a diagnosis I haven’t discussed with them.” (US-PP-1, 17.05.2013)

We see here correspondence with another practitioner’s (US-CP-4) statement that “I also think of assessment and psychotherapy as the same thing” (21.04.2013).

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Diagnosis is seen by this clinician to be a bureaucratic necessity rather than essential to treatment. We see here again how models structure the therapist-patient relationship. Specifically, we note a clear boundary between informing the patient
qua consumer, but leaving the patient qua patient reliant on their own insight: the
‘label’ goes to the outside world, but cannot drive a patient’s understanding of their internal world.

Interestingly, other psychoanalytic practitioners, when questioned whether they wouldn’t give a diagnosis of NPD if the signs were present, tended to give responses like: “Why would I do that? If it’s there, it’s there. End of story” (DE-P-12, 17.02.2014). A matter-of-factness is present here, as if this fact were self-evident. But the same conviction was found in the more orthodox analysts quoted above. What seems to make the difference is the theoretical orientation: the less classical analysts are more willing to explore the diagnosis with their patient, which is in keeping with their generally more active role in psychotherapy.

Outright scepticism of descriptive psychiatry also emerged among some practitioners. A French-trained psychoanalyst (DE-P-7, 13.02.2014) paired this certainty with a warning that the same disorder (Störungsbild), could emerge with two very different presentations, such as aggression and inhibition (Hemmung). Separation of descriptive and dynamic diagnoses was echoed by a Kleinian clinician (DE-P-8, 6.05.2014). Not only psychoanalytic practitioners stressed multiple presentations. A more integrative therapist (US-CP-4) gave examples of aggressive and anxious expressions of pathological narcissism, rather than abstractly referencing them. What emerged in these encounters wasn’t a critique of diagnosis proper, but an elaboration of the current classifications’ limitations.
Severity determined diagnosis for other clinicians. A Gestalt therapist described her process:

“So I believe that understanding can be highly effective in treatment, even for people with a strongly narcissistic structure, and then it can make sense to label it thusly. You say, ‘This is a narcissistic process,’ but I don’t think someone would say, ‘You’re a narcissist,’ or ‘You have [NPD],’ unless that’s how it really is. DSM’s portrayal, for example, is quite distinctly a severe narcissistic disorder, then it’s quite likely. But I don’t know if I’d actually work with someone like that.” (DE-CP-2, 8.01.2014)

Explicit appraisal of DSM’s description as “a severe narcissistic disorder” suggests theory also helps define one’s relationship to official taxonomies. We saw earlier that another clinician (US-CP-9) regarded severity as independent from meeting NPD criteria. But despite divergent interpretations of DSM, both therapists advocated sharing the diagnosis with the patient.

It isn’t always theory, however much it has become our usual suspect. Experience can factor into the decision on which diagnosis is ultimately given. Clinical judgement and one’s models are both buffed and culturally contoured, as we saw with the disagreement among schema therapists on “healthy adult narcissism.” Conceptualisation helps determine when relying on experience is acceptable:

“On the one hand, I orient myself to the criteria, but I simultaneously follow my, so to say, own experience and composure (Haltung) as an experienced psychiatrist in this area. In other words, that means I sometimes give someone a [PD diagnosis] even though he doesn’t meet criteria, and sometimes I don’t give someone one when if criteria are met.” (CH-P-1)

CBT practitioners are sometimes stricter on the use of intuition (e.g. DE-CP-1), but this trend doesn’t hold for all CBT clinicians I spoke with (e.g. US-CP-3).
In shuttling back and forth between the abstractions of the manual and the individual case, knowledge on how to deal with deviations is needed. Conceptualisation steps in when manualised decision rules waiver in actual practice. We see again the role of situational factors in determining whether a complaint rises to the level of pathology.

I probed the respondent for examples of these two diagnostic practices. He described times when following DSM would yield a false positive:

“[O]ne example would be when someone meets criteria, but I get the impression it’s a situational, crisis-driven difficulty where the certainty’s not there that this is permanently the case. That would be the case with young adults or also adolescents. I’d tend to be careful there, although naturally sometimes it’s possible or [important?] to diagnose a [PD] even then.” (CH-P-1)

Narcissism is then far from an all-or-nothing proposition. It can be “crisis-driven” and effusive. OPD, for instance, codifies this in a conflict axis capturing these types of disturbances. A frequent complaint was that the number of criteria which had to be met for a PD was highly arbitrary. DSM’s focus on criterion presence/absence, as opposed to severity, led some clinicians to make technically ‘incorrect’ diagnoses:

“Conversely, if somebody has very few symptoms, but nevertheless has a marked inner difficulty or pathology, then sometimes I’d also give the diagnosis of a [PD] although you can’t really call them such in the DSM.” (CH-P-1, 22.01.2014)

For one practitioner (A-P-1, 20.02.2014), the distress threshold (Leidungsgrenze) determined severity. If the patient or their surroundings weren’t suffering, then it wasn’t diagnosed. This distinction is made in the DSM’s categorical definition of PD. Subjective distress and the criteria threshold can be at cross-purposes, forcing clinicians to choose which one they will honour. Theory steps in to give the verdict.

In other cases, the setting or number of contacts one has had with the patient is the
determinant factor. A psychiatrist (DE-P-1, 11.02.2014) and a clinical psychologist (DE-CP-3, 22.01.2014) both stated that inpatient stays were an inappropriate time to give PD diagnoses. The former believed there was insufficient time to “validate” a PD diagnosis, whereas the latter offered a more nuanced description:

“[A]t least in the clinical setting we commonly see, when the patient’s therapeutic contact or stay in the clinic begins, I wouldn’t give the diagnosis either because what is the patient supposed to do with it. Typically then they’re, at least in my experience, also offended because they’ve gotten this diagnosis and don’t have any possibility to absorb it or further process it. Psychoeducation is still possible, but there I’d only tell them if I knew they were transitioning into psychotherapeutic treatment, so that it can be worked through. Whereby everyone has the right to be narcissistic without seeking treatment. But I wouldn’t do it because I believe it wouldn’t do the patient any good.” (22.01.2014)

Unsurprisingly, one can diagnose pragmatically (cf. Lester 2009:287-288 on “brokering”; Kirschner & Lachicotte 2001:449-454). The explanation is implicitly sociological: being given a ‘label’ that serves no apparent purpose is felt to be demeaning. Of further import is the clinician’s confession on peoples’ “right to be narcissistic”: there’s no moral valuation expressed in this excerpt. ‘Labelling theory’ has pervaded psychiatric institutions.

One schema therapist (DE-PP-2, 3.02.2014) delayed sharing the diagnosis because of the unpredictability of narcissists. Two alternatives were offered, one where the evidence is overwhelming, and the other where the patient recognised she herself was the problem, whereafter the therapist felt comfortable to share the diagnosis. Both German schema therapists I spoke with endorsed this careful approach to naming the patient’s problems. Related were questions of real world impact. Giving a policeman as an example, the clinical psychologist explained the “four eyes
principle”: the diagnosis had to be confirmed in supervision (or intervision) and then by an outside psychiatrist.

We can therefore identify three basic types of uncertainty which cause practitioners to postpone discussion of the patient’s precise diagnosis: (1) diagnostic uncertainty, (2) uncertainty regarding patients’ responses, and (3) questions of the ‘label’s’ real world impact. Occasionally these outside factors can lead a clinician not to dispense a PD diagnosis, at least officially. Theory helps in DDX, but I suggest that it also enables the clinician to leap these other two hurdles. Experience cannot, in my opinion, be entirely separated from theory in more than an analytic manner. These blend in both practitioner and school, forming a database, and allow the clinician to overcome these different types of diagnostic uncertainty. Fox’ notion of training for uncertainty (1957) extends beyond medicine.

Previous studies of psychiatric work have found systems where two (or more) forms of diagnosis coexist (e.g. Light 1980:173-185; Dobransky 2009, 2011). These classificatory schemes can be broadly lumped into systemic (formal) and private (informal) assessments. The latter includes not only diagnoses held within the clinician (and potentially relevant peers), but also those conceptualisations unique to the therapist-client dyad.

Therapist-patient collusion is witnessed in both North America and Europe, albeit somewhat differently. An American interpersonal therapist said:

“I usually tell the patients exactly what I think and exactly what’s in my reports, so no, I would not not diagnose it. In my private
practice I don’t necessarily throw those labels around, and if required to file something for insurance, if they need something for insurance, I’ll give the Axis I, so-called. We don’t make the distinction anymore in DSM-5, but I will give the clinical disorder and not necessarily the personality disorder because of the prejudice.”

Here it is less collusion and more the practitioner seeking to protect the patient from potential stigmatisation. The patient isn’t held in the dark, however: sharing the content of official reports helps to give the patient a sense of collaboration and cooperation.

In contrast, a COP practitioner suggested filing a PD with insurers wasn’t a problem. Here clients fear stigma, not the clinician. Determining which diagnosis will be sent to the insurer is actively negotiated between therapist and client here:

“… rather the problem is that many clients fear that if – so to speak - the state insurance is given such diagnoses, they’ll then have problems with the insurer. And of course then we show consideration for the clients, and they always have – as a rule – Axis I disorders too. So when we say it’s depression, that’s not a lie. They really have depression. That means that in those circumstances, we’re suppressing (unterschlagen) the [PD] but the Axis I disorder exists nevertheless. So when we make an Axis I diagnosis, that’s also a valid diagnosis. See? But I always do this in consultation with the patient, because I don’t want to harm the patient with a diagnosis so they say, ‘That’ll make trouble with my insurer, I don’t want that.’ And when they say, ‘I don’t this diagnosis to be public,’ then we just don’t do it. If that’s how the client wants it, that’s fine.”

COP is in the CBT family of therapies. In the use of the term client and the high regard accorded the service user’s wishes, however, we see the influence of Carl Rogers’ client-centred-therapy. A different concept of the patient/practitioner relationship is held by the COP clinician, leading him to negotiate the diagnosis. Crossing theoretical frontiers entails an alteration of how the clinician-client
boundary is managed. We can see this distinction already in assessment.

Even where we might least expect it, discussion provides an opportunity for the psychotherapist to bond with the patient. A psychodynamic psychiatrist (A-P-2) suggests a different relationship both to the patient and the any outsiders who might have to see the diagnosis. When asked if he ever didn’t give an NPD diagnosis, despite the signs being present, he said:

“[T]here’s always two levels to that question. The one is what diagnosis do I determine for me, the other is what do I tell the patient and what do I write in the chart (Arztbrief) and what do I tell the insurer. And I find, I should make myself clear, what I personally believe the patient has and then I always have to diagnose when I see it. I find you should always tell the patient what you think they’ve got and how you treat it. One’s duty, naturally, is to do so tactfully, and not inconsiderately. But I find you should do it when there’s a clear consensus about it, what the problem is, and that the patient knows we understand the problem they’ve got, and know how to deal with it.” (A-P-2, 22.04.2014)

Sharing the diagnosis and informing the patient as how it will be treated “tactfully” are matters of professional competence. But this is only the first level of dealing with an ‘achieved’ classification. As Godderis (2011:141) indicates, the report has to be made available to (potentially multiple) others: the hospital, a family doctor, and any insurance and billing forms. Multiple audiences (if only the patient and insurer) raises new dilemmas:

“The second question is naturally, what do I write in the chart (Arztbrief)? What do I tell the state insurance? And that’s very dependent on the national system, it’s also determined by the level of data protection, which are very different in different countries. There are certainly colleagues and certain healthcare systems or settings where one is very taciturn, and where you probably don’t record it everywhere, although one should, but when you want to protect the patient, and keep the diagnosis from going public. But that’s clearly not a medical decision, but finally a, if one so pleases, political question how you handle it. But from the medical
perspective or a therapeutic perspective, the diagnosis should always be openly, I think, discussed and negotiated with the patient.”

This distinction between the “therapeutic perspective” and “the political question” will be further discussed below. Suffice it to say that clinicians have the patient’s needs in mind whilst navigating assessment.

Conceptualisation dictates how the psychotherapist relates to the patient, but the consensus that diagnosis is to be shared with (and translated for) the patient is incomplete. That old standby, the minor differences of narcissism, steps in again and overshadows the similarities I have suggested above. My findings invert Sulzer, whose “providers [who share and prepare] were in the smallest of minorities of [her] respondents (and [her] sample was undoubtedly biased towards advocates for these patients” (2012:68). What do clinicians’ models tell them about the next phase, where the diagnosis is sent out into the world? How does theory guide the navigation of bureaucracy?

(IV) Dispersion: “It has more to do with how society deals with the label”, or an undercoat-overcoat theory of moral valuation

Collectively my informants suggest that while ‘labelling’ can and does happen in the clinic, stigma and other negative effects tend to come from how outsiders handle the diagnosis. Dispersion matters because it roughens resemblances, and has a broad impact on patients’ lives. As suggested with the “four eyes principle” (DE-PP-2), a policeman may, for example, not be able to carry a gun if given an NPD diagnosis. Negotiating diagnoses or using comorbid diagnoses as the label of record defeats the
purpose of a standard nomenclature: if our counts now are inaccurate, any predictions based on them will be invalid (cf. Whooley 2010). Treatment planning, and even the design of taxonomies, are in turn affected. Analytically, dispersion is relevant because it reveals an error in sociological theorising.

We’ve seen one example of this dispersion effect already in the TFP psychiatrist’s (A-P-2, 22.04.2014) distinction between “medical” and “political” decisions. Brown (1987:41; cf. Kirk & Kutchins 1992:238-244) suggests this in his quotation of a supervisor at a community mental health care centre: “Use ‘diagnosis deferred’ in most cases for pre-release. These will be legal documents and may be used in court. You do this because you don’t know how other people will interpret the diagnosis.” Much of his paper addresses “social functions and mixed agendas of diagnoses” (42-49), which conforms to my depiction of dispersion as a multiple audience problem. He denotes an “organisational arena” (44-47), a “professional arena” (47-48), and a “societal arena” (48-49). Bowker and Star (1999, see especially 148, Table 4.1) give a complementary list for the ICD: national versus international (141-144), state versus individual (144), doctors and epidemiologists and statisticians (144-146), and industrial actors, including insurance (147), industrial (ibid), and pharmaceutical firms (147-148). Labelling theory has been too narrow, too individualistic in its focus.

I propose therefore an undercoat-overcoat theory of moral valuation: the official diagnosis (or patient behaviour) acts as an undercoat of paint on car, onto which the overcoat (pejorative label and/or negative moral valuation) is then applied. Two
distinct social processes are conflated. A diagnosis cannot simply can be hidden under a mattress: it travels. How and where it travels, and how border crossings are managed are of societal and sociological import. Dispersion has potential consequences for governments, anti-stigma campaigns, insurance companies, and even professional socialisation. In other words, how lots of money is spent, and the quality of scientific findings are at stake.

When we examine assessment as a stepwise process, its embeddedness in a broader social context becomes apparent. One clinician’s description of sharing a diagnosis implies that the danger comes when information is transmitted to non-experts:

“So I’d always impress upon the patient that their disorder isn’t purely disadvantageous. The whole question of whether ‘labelling’ is negative, that’s true for many diagnoses, and depends on what audience (Zweck) you’re writing for. For the state insurance or something else, you’d always proceed cautiously, and when in doubt, you might talk about anxiety or depression instead. So when I stick to using acknowledged terms (Krankenbegriffe) like anxiety and depression, I don’t mention the [PD]. In certain situations, that can make sense, naturally. But really it has more to do with how society deals with the label.”

(DE-CP-5, 12.03.2014)

A more literal translation renders Zweck as purpose, and my word choice admittedly does suit my analytic aims. I contend that even translated thusly the informant still points to an audience issue rather than a psychiatric problem. Such creative diagnosis to avoid stigmatising the patient has been noted by others (see Kirk & Kutchins 1992:232-233; Luhrmann 2000:42; Whooley 2010).

Another clinician (US-PP-3) expressly cited this ‘downgrading’ as what he called the politics of diagnosis. He suggested that there are multiple audiences who might not
“understand it”, including life insurance companies\[^{32}\], court-appointed psychologists in child custody evaluations, and health insurance firms. Of these, the last was the most significant. In response to a question about not giving the diagnosis, he said:

“At least in this country, you put down a diagnosis if you’re billing an insurance company, and you tend to prefer Axis I: major depression, generalised anxiety disorder, panic disorder, something like that, because that flies with insurance companies as being more of an illness. If you just put down a [PD], I think insurance companies will pay for it, it’s legitimate, but they begin to question health implications of that. Except for one, which is borderline [PD]. If you put down borderline, they know it’s a person who needs to be in treatment... But that’s sort of the politics of it.”

(US-PP-3)

He explicitly addressed the audience problem, distinguishing between “my mind”, “my notes”, and “something that maybe is going to go out somewhere to something else.” Even with fellow clinicians, there are snags: court-appointed psychologists in their “due diligence will try to contact the therapist if the person’s in therapy.” Two basic problems surface: confidentiality complications, and clarification. At least in this respondent’s recollection, they are interlinked. One is left in the awkward position of sharing an open secret which may not violate confidentiality in letter, but certainly does so in spirit:

“And they’ll ask about substance abuse and they’ll ask some of those sorts of questions. You’re free not to answer, but sometimes if you say, ‘I’d rather not answer,’ if they ask, ‘Do they have a [PD]?’ and you say, ‘I’d rather not answer,’ that’s sort of like saying, ‘Yes, but I’m not telling you.’”

(US-PP-3)

Uncertainty swirling about a colleague’s perception of narcissism creates a need for clarification, if not outright translation. Even the lingua franca is not fail-proof:

“I don’t know what their threshold is, or again, this is the trouble – the term narcissism means so many different things to so many different people, and particularly with the DSM it tends to be a

\[^{32}\] Private health and life insurance companies were mentioned by DE-PP-2 (3.02.2014), but without referencing politics.
pretty pejorative label, a pretty negative label. So if you say to somebody doing child custody, ‘Yeah, I think he has [NPD]’ – I had one guy that went around saying, ‘Would you say that he could be easily upset and humiliated by minor slights?’ And I said, ‘I guess I could agree to that,’ and that was kind of where we left it. I wasn’t going to go into the whole thing, cos I wanted to make sure he and I were talking about the same thing.” (US-PP-3)

Court-appointed psychologists aren’t the only psychiatric professionals who might use disorders as a label in Scheff’s (1998) sense. Two factors might lead to such unfortunate events: partial understanding (“A little knowledge is dangerous”) and inexperience (“you hear among less experienced clinicians”). In answering a follow-up question as to who misuses PD diagnoses, he pointed first to which labels he felt this happened with. He listed narcissistic and borderline before continuing:

“We have in the DSM histrionic [PD], but we don’t have hysterical personality. Being from psychoanalytic point of view, I think of hysterical issues and I don’t think of them as necessarily having to do with women, and I don’t think of them necessarily as a put-down. But any of these labels can seem a put-down, and you hear among less experienced clinicians, ‘Oh, he is so narcissistic. Boy, is he obnoxious,’ or ‘She’s borderline, I hope I don’t have to treat her,’ ‘Oh, this is a hysteric, she’s just all over the place, very dramatic,’ all this kind of thing.” (US-PP-3)

We return here to the problem of empathy, and the idea that is both an ability and an accomplishment (Ferrara 1994: 113-118, Ch. 7; Ruusuvuori 2005; Wynn & Wynn 2006). The concern arises because patients aren’t understood intrapersonally, but interpersonally and in terms of a block in the system (cf. Commons Treolar 2009; Koehne et al. 2012:49 on this dual usage of “borderline”; Lester 2009 on “borderline talk”). “Daily staff actions must be defined and presented as expressions of observation, diagnosis, and treatment” and thus must be translated (Goffman 1961a:384). I’d argue against Goffman that it isn’t the tinkering model per se which generates these empathic failures, but rather the stripping away of ritual elements.
What is missing in these instances is not the technical or contractual chunks of interaction, but its ceremonial stuff. Ritual elements involve taking – and affirming – one’s interlocutor as a full and meaningful contributor to the interaction, someone trying to solve the same basic problems we are. It means taking the role of the other:

“And they’re used as pejorative labels rather than as descriptive labels. There’s where I would say… Psychiatric nurses, [and] social workers on in-patient units, ‘Oh, he’s so narcissistic,’ and ‘He’s a pain in the ass’ is what they’re saying. They’re not saying he’s this type of personality that causes him to suffer, they’re not concerned about his suffering, they’re concerned about their suffering being with the person. So it’s a whole different story. ‘Oh his poor wife, she has to put up with this arrogant asshole,’ or something like that. That’s what they’re saying with the label. It doesn’t have that empathic interest in how the person operates, it’s more, ‘What kind of management problem are they going to be for me?’”

(US-PP-3, 9.05.2013)

These then are the interactional outcomes of the “constant conflict between humane standards on one hand and institutional efficiency on the other” (Goffman 1961a:78).

A second understanding is also possible: labelling serves to heighten staff solidarity, and it’s also a form of emotion work. These linguistic barricades prevent Goffman’s (ibid:82) “cycle of contact and withdrawal.” If there is no cross-team collusion (i.e. the staff member never falls into solidarity with the patient), there is no chance to be burnt either by colleagues or the patient. A third explanation could be that this is essentially to generate a sense of control or otherwise save face. It is likely some combination of all three.

Two distinct types of dispersion emerge from this account: first, we have diagnoses (which may or may not be official) which are adapted to local purposes (cf. Light 1980:177-179 on managerial and therapeutic diagnoses; Kirk & Kutchins 1992:243-4 on research versus organisational uses of diagnosis). In the extreme case, as with the
insurance adjustor or even some psychiatrists, it can serve an exclusionary function (cf. Dobransky 2009, 2011 on informal labels and exclusion). A retired forensic psychiatrist emphasised that even Kernberg’s definition of NPD was sometimes used to shut people out of therapy. When I (proudly) said that hadn’t been Kernberg’s intent, he agreed before quickly correcting me. He indicated Kernberg sometimes comes across as “malicious” (bösartig) and presents “extreme cases” (DE-P-X, 30.01.2014, fieldnotes), thus causing exclusionary diagnosis.

The other type of dispersion is what I’ve called clinician-patient collusion. I had read in a COP manual that the purpose of diagnoses is exclusively to glean practical therapeutic measures. This comment prefaced the question as to whether there were times he would not diagnose NPD. He explained that the quote referenced the “in-house” diagnosis that would direct treatment:

“What you’re talking about is the supervisorial diagnosis. That diagnosis practically leads us towards proper [treatment] indications, and we say, ‘If the clients want a diagnosis, we tell them the diagnosis, but explicate what it means.’ And the public diagnosis is always critical, because at least in [Germany] there are a lot of people who consider a [PD] diagnosis fatal. They’re not treatable, severely disturbed, and therefore we’re always careful with the official diagnoses, because we don’t know how it’s going to land out there. Yeah? So I only publicly submit an official diagnosis after consulting the client. If the client approves of our sending the state insurer a [PD] diagnosis, then we submit the official diagnosis, and otherwise not.” (DE-CP-6, 25.02.2014)

We see here two of Whooley’s (2010) workarounds in combination: “fudging diagnoses” (460-462; Greenberg 2013:128), and “negotiating diagnoses with the patient” (462-3; Greenberg 2013:70). His study recognises “that the professional authority of the psychiatrist is expected by the patients and is useful for the treatment” and that “for patients with more severe illnesses it is not feasible” (463).
BPD and NPD provide interesting exceptions to the latter: both are serious, but negotiation happens nevertheless.

By leaving the consulting room, diagnosis is stripped of context. However, even official diagnoses, the *lingua franca*, are far from universally understood. Our intrepid analyst from above (US-PP-3), suggests that this stems from researchers’ and clinicians’ different needs:

“What I have found is most clinicians *don’t* do that, and *don’t* go back and look it up every time they think about it, and if they don’t remember the criteria, they don’t *care*, they just kind of use the label the way they use the label. Because the criteria were developed, there’s all kinds of research reasons to have good criteria for diagnoses, but if you’re working clinically, it’s not the label per se – ‘does this correlate with this?’ is not your question. People tend to be less strict with making sure they meet all the criteria, do you have to have five out of seven or whatever. Somebody might have *two* out of seven and you say they’re narcissistic, because the two are pretty pronounced.” (9.05.2013)

We saw this very practice earlier (CH-P-1, 22.01.2014). A clinician is interested in interpersonal correlations to make distinctions, but their focus is devoted mostly to intrapersonal considerations.

An alternate explanation is that this is simply poor clinical practice, and does not reflect on the veracity of the official classification. Testimony of the “shoe size” psychiatrist (DE-P-3, 13.01.2014) suggested that this is a systemic problem. An American (US-CP-4) indicates that disordered patterns only make sense in context, and there is (as DE-P-3 said) a loss of data in the translation from situated symptoms to a DSM diagnosis. As indicated by Whooley (2010:458-460), “alternative taxonomies” can be used to organise one’s thoughts and then translated into DSM
“I think it's important to get specific about what are the contingencies and functions of those problems, in the context of what a person's like in general. Now I think once you have a sense of both of those two pieces, then you can retrofit any stupid thing from the DSM you want, right? I think that if you get a really solid idea of what a person's like, and what kind of problems they're having, and what the functions of those problems are, whether they're conscious or not, well, I think that sounds like an X diagnosis to me.”

DSM diagnosis doesn’t direct treatment, whereas this contextual approach to the patient does. What DSM offers is a “shorthand”, but not a clinically relevant picture of psychopathology (US-CP-4, 21.04.2013). My respondents agree with Whooley’s informants (2010:459-460) as to the level of information conveyed by a codified diagnosis, despite being a professionally mixed group (cf. Koehne et al. 2012:46 and Smith 2014 for similar findings). Due to its use by non-experts, then, diagnosis acquires its negative valence often after leaving the clinic. We’ve seen, however, that clinicians themselves might use a diagnosis as exclusionary or, due to an overly technical treatment style, lose sight of what purposes the patient’s narcissism has served. Client-clinician collusion is sometimes a solution to this, but generates new issues higher up the food chain. Generally, conceptualisation helps a practitioner by proposing appropriate ways to relate to both the patient and outsiders with whom information must be shared.

Models broadly shape how a diagnosis is used and understood. There is an audience problem: once a diagnosis leaves the family home, suddenly it may be understood very differently despite the fact that it is intended to be a universal or ‘atheoretical’ category. Descriptive diagnosis appears to open up diagnoses to more stigma: by
stripping away theory, the diagnosis isn’t left with a purely behavioural definition but is instead left open to local interpretation. Local, non-expert readings of narcissistic are often pejorative and dismissive, leading to ethical and scientific dilemmas for the practitioners. Clinicians may find themselves at odds with other psychiatric professionals because of variation in how narcissism is understood. These findings generally indicate that dispersion is the stage of diagnosis where ‘labelling’ become active. While practitioners do disparage, there seem to be good sociological reasons for their bad behaviour. Overall, an examination of this diagnostic stage elucidates an undercoat-overcoat model of moral valuation.

Once a diagnosis has left the nest, there is still one phase of assessment left. Defining discrete disorders was meant to guide research and allow disorder-specific treatments to be developed. But we’ve seen that for at least some practitioners, the DSM just can’t crack that egg. Broadly speaking then, how does a diagnosis guide psychotherapeutic practice? Part of the argument for DSM ran that a standard classification would lead to disease-specific treatments (Kirk & Kutchins 1992:235-237). Correspondingly, part of the critique has been that, with a few exceptions (depression, borderline PD, eating disorders), this rationalisation has not occurred. Can an Ansatz serve the shepherding function that classificatory schemes cannot?

(V) Direction: Who leads when diagnosis dances with treatment?

An assessment specialist (US-CP-7, email, 2.03.2015) points us toward the diversity inherent in direction: “Assessment SHOULD guide/ determine the appropriate treatment, but in the real world, it does so only moderately well.” A process of
channelling occurs, wherein diagnosis helps to lead the treatment process forward. What exactly do clinicians do with this data they’ve discovered and dispersed?

Assessment is sometimes seen as the first step in treatment: helping the clinician to set the parameters of treatment, including duration, intensity, and type. As virtually all my informants said, narcissists don’t typically come to treatment voluntarily or do so because symptoms of another disorder are interfering with their lives. The first challenge is to pinpoint the PD amidst their other problems in living, which tells clinicians this is liable to be a long trek: “When I’m dealing with, for example, someone with chronic depression and I have the impression there’s an underlying [NPD], then I’d treat them differently from someone with a depressive episode. Intensity and length of treatment” (DE-P-8, 6.05.2014).

More personal factors also direct treatment. Patient attributes influence the choice of therapeutic approach more than their illness, at least with pathological narcissism:

“Because the choice of treatment modality (Verfahren) hinges on several factors, how much insight the patient has and what they want, amongst others naturally. There are plenty of narcissistic patients who just want some kind of coaching or counselling (Beratung), and so tend towards self-optimisation. We question that, of course, but if the patient is ultimately looking for that level of support, we’d provide it. In contrast, if [the patient] had more insight (Zugang) in their interpersonal problems, that they’re lonely, sad, feel guilty, and is processing the past, life experiences, then we’d tend to recommend a psychodynamic, analytic psychotherapy.” (DE-P-8, 6.05.2014)

Several other practitioners also explicitly advocated this type of tailoring (US-CP-5, DE-P-6, DE-P-9). Others (e.g. US-CP-4) who varied their treatment approach frame this more in terms of the patient’s psychological disorder than of personal qualities.
Even severity is in some ways circumstantial.

“The question of outpatient, inpatient, or day hospital, for me that’s partially determined by severity, is outpatient psychotherapy sufficient, is it even proximately available, how chronic are the symptoms, how obdurate are their life circumstances, does someone need relief from external stressors, say in their profession, we’d decide based on that. But we decide not so much based on the diagnosis, but more on the severity and the social circumstances if someone’s treated inpatient, partial programme, or outpatient.” (DE-P-8, 6.05.2014)

Another psychodynamic practitioner (A-P-2, 22.04.2014) used Kernberg’s levels of personality functioning to determine severity, and stated that, “more mature narcissistic personalities… I’d treat them laying on the couch, three, four times a week.” Similarly, a schema therapist clarified that on explaining the diagnosis (in schema terms), she would also clarify that the goal of treatment “isn’t to become more successful and buy even more Porsches” (DE-P-2, 10.12.2013).

Most conceived of it as a feedback loop, wherein diagnosis informed treatment, which would then reveal new information about the patient (cf. Antaki, Barnes, & Leudar 2005:630). One relational psychodynamic practitioner put it this way:

“If you think about assessment and formulation as being an ongoing process, it's always informing treatment. So when you're providing longer term intensive psychotherapy for somebody, your assessment, your thinking process of what's happening for that individual, what meaning can be made of an interaction or an attitude or a behaviour, that will inform your responses to that person so it's constantly informing the treatment. Even at an implicit level, without you necessarily being aware of it.” (CA-CSW-1, 6.09.2013)

We do see subtle differences emerge here because of the philosophy of treatment. DBT, being behaviourist in its orientation, is much more concrete. Rather than
relying on “implicit” understandings, data are explicitly recorded:

“[W]e do the diary card every week, and your session is really dictated by what’s on the diary card. So the assessment is really integral to the whole treatment process. If you endorse suicidal behaviour on the diary card, that’s the first thing you do in the session: address the suicidal behaviour and do a functional analysis of the suicidal behaviour. If there wasn’t any suicidal behaviour, then you’d move on to the next thing on the diary card. So you really set the agenda of what you’re going to do in the session based on what’s in the diary card.” (US-CP-10, 15.08.2013)

What matters is that symptoms are “[operationalised] as behaviourally as possible.”

Theoretical conceptualisation guides the DBT therapist to this type of assessment and understanding. Differences in data collection can be lumped by genealogy: CBT traditions favour instrumentation and concrete evidence (e.g. dysfunctional thought records), whereas psychodynamic schools prefer less tangible (i.e. situational) data.

But in both traditions, the clinician attends to the details of the unfolding case.

Many respondents stated that narcissists typically don’t independently seek treatment. A direct outgrowth of this was that already in the assessment phase, this schema therapist would begin to look for “leverage”:

“How am I going to keep them in therapy? So in other words, is there enough leverage? Do they care enough about the person they could lose if they refuse to engage in treatment, to come to therapy, to be compliant? Because if you don’t have leverage, you don’t have therapy with narcissists.” (US-LCSW-1, 16.09.2013)

We see a general way in which diagnosis directs treatment – it often guides the expectations of practitioners and can help them set specific treatment goals. A Gestalt therapist accentuated the limitations of this approach:

“[A]ssessment can, so to speak, give baseline information regarding the problems or interpersonal patterns. But actually not more. It’s additional knowledge that you can have, and you can use to position yourself as a therapist, that is [proper] assessment.
And when I know that it’s a narcissistic personality, then I of course know roughly what to expect, and it also gives me a little guidance.” (DE-CP-2, 12.02.2014)

A more psychodynamically-oriented clinician highlighted how models shape diagnosis, which in turn helps to determine treatment goals:

“[D]iagnostically your first concern is that base narcissistic disorder, maternal deprivation, can also be found in their development, and then you’ve got to differentiate between Größenselbst [roughly equating a grandiose presentation] and Größenklein [similar to a vulnerable presentation].” (DE-P-4, 4.02.2014)

Interestingly, a German pure practitioner of systemic therapy stressed that a diagnosis of narcissism led him to relate to the patient in certain ways:

“I try not to irritate narcissists, so to speak, and to avoid this narcissistic competition that can easily emerge. And I also am on the spot with every utterance. Practically every formulation is made carefully, so they’re not under pressure to devalue it. So when I have an idea they haven’t had themselves, I’ll say something like, ‘Well, this doesn’t have to make sense right this second,’ or ‘I can imagine that you’re none too thrilled about this idea right now,’ so that they don’t have to worry so much about keeping their self-esteem in homeostasis, and feel less threatened, yeah?” (DE-PP-1, 11.03.2014)

Models are operant, to a greater or lesser extent, throughout assessment. They are, according to my findings, the drivers of diagnosis, which can be schematised with five D’s: (1) discovery, (2) distinction, (3) discussion, (4) dispersion, and (5) direction. Each stage represents a particular type of relationship and how it is to be managed. Concepts serve to order the jumble of a pre-patient's biography, and may even provide the tools for data collection (diary card, STIPO, Young Schema Questionnaire). A clinician’s theoretical orientation even begins to direct how the patient (Phase 3, discussion) and others (Phase 4, dispersion) are related to. We see a

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33 Several psychoanalysts (e.g. DE-P-4, DE-P-11) stressed that psychoanalytic terminology is often metaphorical. It wasn’t about a mother, but “eine Mutterlichkeit” – a caregiver.
classic case of unintended consequences in dispersion, where patient-practitioner collusion leads to systemic errors. More broadly, I suggest an undercoat-overcoat model of moral valuation. The pejorative use of labels is regrettable indeed, but entirely understandable in ritual and relational terms. A psychotherapist emerges as neither saint nor sinner, but as a sociologist, ever attentive to context and cues. Treatment channelling (phase 5) can be conceptually inflected either directly (e.g. DBT and TFP’s hierarchies based on different types of data collection) or indirectly. Psychiatrists who are not psychotherapists, however, may well diagnose differently, even with PDs: The lone biological psychiatrist I spoke with was at the very least familiar with psychotherapy, and thus ‘impure.’ Further research is needed to discern differences and similarities between physiological- and psychotherapeutic- psychiatrists. We’ve seen some ways in which the patient-therapist relationship begins to be shaped already with an NPD diagnosis. How does theory directly impact psychotherapy and the way different theoretical schools interact? What similarities and differences can be found in the various treatments for NPD?
Chapter 6: Interventions, Interests, and Emotions: Meet the Minimal Medical Model

In this chapter, I confront that blurry Bigfoot sociologists see: the medical model (MM). No one except for perhaps Goffman (1961a) offers a clear definition, but what seems to be meant is a disease model paired with a paternalistic patient-provider relationship. A German (Streeck 2008:174) proposes a MM of psychotherapy, wherein “psychotherapeutic competency would prove itself by recognising and eliminating inner psychic causes underlying the mental disorder.”

Sometimes a biomedical model is referenced, which in psychopathology means following Wilhelm Griesinger in saying that “mental disease is brain disease” (cited in Engstrom 2003:51 and Porter 2002:144). The debate on whether or not to include the phrase “mental disorders are a subset of medical disorders” in DSM-III’s definition of mental disorder (Kirk & Kutchins 1992:111-116) seems to confirm some scholars’ equation of the MM and a biomedical approach. Almost all the psychotherapeutic traditions I studied explicitly reject the MM. Yet the common wisdom in medical and psychiatric sociology is that medicalisation is on the rise. Even psychoanalytically trained psychiatrists don’t resist this amorphous MM (Smith 2014).

A paradox is present: sociologists say medicalisation is ever on the march, and psychotherapists denounce the MM. I call this conundrum the medical model morass. Now the MM – as social scientists construe it – dictates a certain patient-
practitioner relationship, and by my reading, argues that this results in oppression (cf. Ainsworth-Vaughn 1998 and Hunter 1991 for perspectives closer to my own). The only way to counter these claims is with evidence: Through an interrogation of my informants’ description of their relationships to their patients, I hope to demonstrate that the monarch MM doesn’t match with actual practice.

Following Goffman (1961a), we would expect a rational three-part process of “diagnosis, prescription, treatment” (331) treating “the body as a serviceable possession – a physicochemical machine” (340). Such a MM is readily applied by psychiatric professionals: “A uniform professional courtesy shown to patients is matched with a uniform applicability of psychiatric doctrine” (351). There are then essentially three components: an expert-client relation (paternalistic as well as rational in the standard account), a disease model, and a belief in some universal disease process.

This chapter discusses (I) how different psychotherapies structure their relationship to patients (and to an extent, one another), and (II) physical treatments and the biomedical model. Closing the show are discussions of (III) how treatments relate to the MM itself, and then (IV) the proposed minimal medical model. Throughout the chapter we will continue to see the remarkable resemblances between different theoretical traditions, and our old friends, self-interest and competition. Sometimes fierce opposition between schools (mainly, but not always, at the psychodynamic-behavioural divide) can conceal their common goal: attempting to build the patient’s capacity to tolerate difference, imperfection, shame, and conflict.
Let’s begin with an experienced psychiatrist, and how he’d advise someone seeking a consultation on an NPD patient:

“It depends on the purpose of the consultation, but if I saw somebody who had a diagnosis of [NPD], I might still suggest they try psychotherapy if they haven’t tried it before, just to see what happens. But to me it would still be a warning sign to make that diagnosis, which is to say, ‘Hey, this may not work, this may not be so easy.’” (CA-P-1, 21.08.2013)

Narcissistic patients have a poor prognosis by this respondent's rating. This beginning is not only marginally medical, but extremely so. Traditionally course and aetiology are the hallmarks of diagnosis, and respectively indicate prognosis and treatment. Our informant above intimates that the relationships aren’t so straightforward here. Psychiatric models generally propose an aetiology (e.g. insufficient or missing emotional regulation skills) and a corresponding treatment (skills training plus individual psychotherapy). It isn’t just psychoanalysis where causality is central, and “all therapeutic action is predicated upon key assumptions about causes of distress” (Davies 2009:147).

Now this particular respondent appears to be a shaky base for generalisation. He is perhaps the most ‘scientistic’, stating that, “I think we have to agree on these definitions. One cannot have a personal take on them” (CA-P-1, 21.08.2013). While most psychotherapies I studied explicitly deny using the MM, it is implicit in all of them (and this is probably for the best). My evidence is, admittedly, highly variable: practitioners’ portrayals of the treatment range from merely mentioning manualised methods (“cognitive-behaviourally and with [ST],” DE-CP-1, 5.03.2014) to adumbrations of techniques and in some cases entire therapy methods.
Germanophone Europeans tended to be briefer in their descriptions, but this is largely because many capped our interviews at 30 minutes. A theory calls for a precise repertoire of interventions, and yet even pithy depictions betray blending. How do the various schools build rapport with the patient, and what does this tell us about their relationships?

(I) How Treatments Relate: Amalgamation, Segregation, Translation

Interventions can be understood in the context of interrelating theoretical schools. There are (at least) three general modes of interaction, including amalgamation, segregation, and translation. Amalgamation represents blending interventions or ideas from different therapeutic traditions into one’s practice. Contrastingly, segregation is the partial or complete walling-off of one’s approach from outside influence. Translation converts text or speech from one language into another. Varieties include lay-psychotherapeutic, theoretical-standard terminology, and concept-concept translation.

(I.1) The Kernberg-Kohut Controversy: Empathy or Interpretation?

I serve the debate distilled. Kernberg advocates rigorous interpretation of the transference, and Kohut empathic mirroring. A more aggressive narcissist is found in Kernberg’s work, and a more fragile narcissist in Kohut’s conception. To call it a controversy is almost an understatement, as some people believe it to continue into today. I focus now on their seemingly incompatible treatment recommendations.

Amalgamation is most salient now, as it was recommended by several clinicians. A
TFP practitioner precisely outlines the procedure:

“The patients I referred to as pathological narcissists need a treatment approach (Behandlungstechnik) in which the therapist combines something which Kohut described and what Kernberg described, if you please. I think what Kohut described very well is that you always have to factor in the patients’ irritability (diese Patienten immer ihrer Kränkbarkeit mitdenken muss), and also give them enough recognition (Anerkennung), what Kohut termed mirroring.”

In practice, then, the Kernberg-Kohut controversy appears resolved by their union in practice. An interpersonal practitioner mentioned a paper (Benjamin 1987) which “[harvested pretty good points] from each, but in terms of the basic treatment, if I had to pick one, I would come in on Kernberg’s side” (US-CP-8, 20.08.2013). She explicated that, “you have to have a theory that will direct your confrontations, and it is very tricky thing, they do not like it.” One group of US clinicians didn’t blend, but rather sequenced, Kohut then Kernberg: all reflected back until patients asked them to begin intervening (US-CP-1, US-CP-2, US-CP-9).

Some presentations of pathological narcissism, however, require a more strictly Kernbergian approach. The patient’s demeanour, then, can call for segregation of different techniques drawing on ‘opposing’ theoretical traditions:

“In terms of getting at some of the things that are more sensitive about how they view themselves, about how they can be regulating their sense of esteem, I don’t tend to take a real directly confrontational approach, unless it’s somebody who’s very grandiose and has an aggressive side as well.”

In a sense, then, this psychodynamic practitioner responds to aggression in kind.

Though both Kernberg and Kohut are psychoanalytic thinkers, their union appears to
come in a way which is compatible with DBT. One psychodynamic psychiatrist presented the dialectic of “supportive enough” and “confrontative enough” as a general framework for treating narcissists:

“One psychodynamic psychiatrist presented the dialectic of “supportive enough” and “confrontative enough” as a general framework for treating narcissists:

“Above all, I try to work on the relationship, and try to find a happy medium (Mittelweg) between ‘supportive enough’ and ‘confrontative enough,’ which isn’t easy. If you’re just ‘supportive’, then you get nowhere, and if you’re only ‘confrontative’, then you also go nowhere.”

(CH-P-1, 22.01.2014)

When asked how this could be managed, he gave an answer that seemed satisfactory in the moment, but with time appears more and more ambiguous:

“Yes, well, in a certain manner I follow the patient closely, also how much the patient – for example – can tolerate, how resilient they are. ... But naturally that’s really a question of experience, and of therapeutic course (Therapieverlauf), of process.”

We again encounter the therapist as microsociologist, following the momentary ebb and flow of esteem (self and otherwise). Experienced therapists, I argue, are more attuned to situational cues (e.g. microexpressions, body language, mismatches of tone and content) which enable them to spot vulnerability. One German psychotherapist (Streeck 2008) points out that these paralinguistic cues and nonverbal behaviours (of both self and other) can impact the therapy and thus bear attention (181-183; cf. Yeomans et al. 2015:155 on “listening to the three channels of communication”). Flashes of emotion can be extremely important, particularly in psychodynamic treatments. All therapies require such monitoring, a deep engrossment in the situation, in order that one might have an idea what’s coming and how one’s interventions are being received. Ritual elements are therefore crucial.

Shuttling between Kohutian reflection (“to keep them there,” US-CP-4, 3.05.2013)
and Kernbergian interpretation (to promote reflection and change, US-CP-4) serves to keep this balance. Some clinicians stressed the time dynamics of this blend, emphasising that one must gradually build to interpretative work:

“I would work primarily transference-focused, but simultaneously considering the patient’s individuality. Sometimes when it’s not appropriate (nicht angebracht ist), for instance, to work more confrontationally, because the therapeutic alliance isn’t very solid yet, then I’d be a bit conservative (zurückhaltend) with interpretation, for example, in the transference, that should show itself in the transference one should first work very containingly (haltend), work supportively, and then build in more and more transference-focused elements when the psychotherapeutic relationship’s a bit better.“ (CH-P-2, 20.02.2014)

We see here shadows of COP’s Beziehungskonto: one cannot simply stomp in and suddenly make proclamations. A bond must be formed before one can link unconscious material with behaviour expressed in the patient-therapist relationship (i.e. make transference interpretations). An ability to withstand the patient’s tests (to again use COP terminology), and respect for the patient must be exhibited. Ritual regard looks different in COP versus TFP, but in both cases it is foundational. Another clinician (DE-CP-4, 12.03.2014) gave further guidance, saying, “When you consider the three steps clarification, confrontation, and interpretation, [narcissists] need minimal (wenig) confrontation.” Again, it’s about establishing that the narcissist’s face isn’t constantly at risk. We turn now to those central social emotions, shame and blame.

**(1.2) Shame and Blame in Psychotherapy**

We could conceive of the above amalgamation as behavioural shaping, gradually building the patient’s tolerance for conflict, confrontation, and the possible shame these might bring. In effect, therapy with narcissists represents an exposure
treatment whereby shame and conflict are brought in larger and larger doses to enable the patient to function:

“So a simple way to move this forward without taking up too much of your time is this narcissistic guy has to learn how to be an imperfect person in an imperfect world, rather than a perfect person who knows everything and can ideally control all of reality to maintain that view. … And now he is working to end his therapy as, as I said, as an imperfect person in an imperfect world who can tolerate that. And then have much more modulated ways of relating to people and expectations for self and other.” (US-CP-1, 6.06.2013)

Imperfection and difference must become acceptable features of the narcissist’s world for treatment to succeed. A psychoanalyst offered similar advice:

“So one has to gradually assess the capacity of the patient to tolerate difference and disappointment. These are elements in disillusionment which are part of what inevitably follows from recognising the difference between that person and somebody else.” (US-PP-1, 23.05.2013)

A young practitioner (DE-CP-3, 22.01.2014) proposed irritability desensitisation, whereby “patients purposefully get external negative feedback, and then check how that feels and so learn a sort of habituation so they don’t react with such irritation.” She hadn’t done it, and was “not so convinced”, but indicated it as a possible element (Baustein) in CBT. Positive results came from a single experiment in this vein by a more interpersonally-oriented American (US-CP-4, 3.05.2013). An ST psychotherapist (DE-P-2, 20.12.2013) also endorsed such methods, where ‘limited reparenting’ is “one therapeutic technique, in which you try to quasi induce shame (quasi die Beschämung auszulösen)” with vulnerable narcissists.

Both this CBT therapist (DE-CP-3) and a COP clinician (DE-CP-6, 25.02.2014) recommended graded tasks to bring grandiose fantasies closer to reality. Young and
colleagues (2003:395) state that “[t]he goal [of treating NPD] is increased vulnerability with less overcompensation and less avoidance.” Different specific techniques exist, but share a singular purpose. Yeomans and colleagues (2015), for instance, suggest that the aim is to work from a narcissistic to paranoid through to a depressive transference over the course of treatment (302-4). Theory here throws up certain possible approaches (e.g. rigorous interpretation of the narcissistic transference) using a particular terminology, but the shared aim indicates a common foe.

A German psychoanalyst (DE-P-3, 13.01.2014) initially appeared intractably idiosyncratic, but in this context his general admonition makes sense: “the foundation is tripping [these patients] up. You have to become palpable as someone else, as other.” He explained narcissists have to develop a tolerance for difference (Alteritätstoleranz), which rules out interpretation and the analytic “poker face”:

“But there have been various interventions (Interventionsverfahren) developed in Germany, that are such that you position yourself. So when I look at you, I get queasy. Queasy or threatening (brenzlig) or something like. Then the patient can ask themselves, what is about me, the patient, that’s making the therapist so queasy. Then they notice there’s someone outside themselves, and so that’s the baseline.”

This can be done in any therapy modality, but “the principle is to put yourself in the way” regardless of how one chooses to treat. His pathway to this result remains unique, at least amongst my interviewees. While others spoke of omnipotent control, he references “the search for harmony”; but the goal remains bursting the bubble, being seen as autonomous.
Gradually, distance must be built between individuals and their symptoms in order for them to see the costs. We might phrase this in Goffmanian (1963b) terms: a (compensatory) narcissist is someone who sees themselves as discreditable, who approaches “normals” with “hostile bravado” (17-18). They could be taken as passing (Goffman 1963b:73-91), which potentially explains anxiety (87), and feeling torn between social groups or roles (87-88). I propose that cardinal and compensatory narcissists share (1) a necessity “to be alive to aspects of the social situation which others treat as uncalculated and unattended (ibid:88), and (2) they “may be [their] own audience or may imagine an audience to be present” (Goffman 1973:81-82). Sociologically, we would expect compensatory narcissists to “[decline] or [avoid] overtures of intimacy” to “avoid the consequent obligation to divulge information” (Goffman 1963b:99). Cardinal narcissists ought to feel entitled to both “the right to direct and control the progress of the dramatic action” (Goffman 1973:97) and to be “made the star, lead, or centre of attention” (ibid: 100). Inevitability “[i]nformation incompatible with the individual’s [self-image] does get conveyed” (Goffman 1963a:103), or in the compensatory case, incompatible with their self-presentation.

Good sociological reasons exist for all therapies, no matter how behavioural, to follow the Freudian dictum that every symptom has a sense. (And I contend they do.) This understanding is central to empathising with ‘difficult’ patients such as narcissists. Another clinician pointed to the role of empathy in recognising “the [patient’s] need for an audience as something they need because of being a vulnerable, insecure, whatever person” (US-PP-2, 9.05.2013).
Empathy, or being able to understand why the patient’s actions make sense to them, helps to keep psychotherapy afloat in two ways: both by keeping the practitioner meaningfully engaged in the moment, and not alienating the patient. One psychologist (US-PP-3, 9.05.2013) suggests a delicate balance: with patients too similar to the practitioner “you don’t see anything”, and with those too different one lacks a “basis” for working with then.

As common sense dictates, the only way to keep a patient in therapy is by building interest in them. Clinicians seek to intrigue patients, to draw them in. Building rapport in an (at least initially) artificial relationship represents a technical challenge for the clinician. One way to do this is to recruit the patient as a sort of team member:

“…[T]he approach (Ansatz), in my eyes, would be where possible, not to proclaim narcissism as the problem, but rather the underlying need that drives someone to behave such that it becomes difficult for and straining their environment. That means not identifying missing self-esteem or that they must place themselves over others or that they always feel less (schlechter) than others as a problem, rather the need, ‘I’m not ok, I don’t deserve to live when I don’t earn praise, I’m different from everyone else anyway.’, to place these themes in the therapy’s foreground and so to peer behind this symptomatology. … So together we try to understand what’s underlying it. I’m no cleverer than the patient in that moment, rather I throw myself into this quasi joint search. That would be the technical trick here. (CFD laughs.)” (DE-P-9, 12.03.2014)

A Gestalt therapist (DE-CP-2, 8.01.2014) spoke less in terms of teamwork, rather suggesting that the goal is “to make the patient curious about positive change” because people “learn through passion or through curiosity.” She emphasised that it was essential “to give them the feeling that the way they are is perfectly ok.”

Another practitioner (US-CP-4, 3.05.2013) equally stressed curiosity, but used test
results to engage patients.

Central to any such technique is not shaming the patient (e.g. US-CP-4, 3.05.2013), but to give them a feeling of comfort and security when beginning treatment (DE-P-9). Motivational interviewing was used (CH-P-2, 20.02.2014) both early in treatment and at crisis points for exactly these reasons. Such considerations were highly consequential in one psychiatrist’s endorsement of group therapy for narcissists:

“[C]entral to group psychotherapy is that it doesn’t produce a dyadic object-relationship, rather a unique group-dynamic with many individual relationships. For a narcissist, a dyadic relationship has a very substantial potential for self-esteem destabilisation. Every expression – put it like that – of the analyst in the dyadic situation leads to uncertain self-esteem (Selbstwertenfragestellung). This is naturally much easier to handle with these patients in group psychotherapies, because the interaction is shared amongst multiple people and so group psychotherapy is much more tolerable. Besides it also has a huge significance for these patients when they recognise how they position themselves in group hierarchies. They learn, so to speak, to order themselves in a relatively complex social surface (Beziehungsgeflechte) [and] so achieve something that they [couldn’t] in individual therapy.”
(DE-P-5, 28.02.2014)

This group psychotherapy is more process-oriented, which fits with his psychoanalytic justifications for combining individual and group psychotherapy. In contrast, DBT group therapy is skills-oriented in the first year of treatment. Different conceptualisations of the illness lead directly to diverse interventions. There is, however, an underlying similarity. A systemic therapist (DE-PP-1, 19.02.2014 email) elaborates that: “Ultimately the preference (Vorliebe) for dyadic relationships (instead of groups or teams) is to be taken as an important trait (Merkmal). Groups and teams seem to generate a particular insecurity regarding self-esteem [and] -
acceptance for the patients.” I take this as further evidence that models can obscure as much as they clarify.

We therefore see more concept or school-specific ways in which the relationship might be built up. Understanding the needs behind the narcissism (DE-P-9), using test results a springboard for self-inquiry (US-CP-4), group therapy, and “giv[ing] them the feeling that the way they are is perfectly ok” (DE-CP-2, 8.01.2014) are some approaches we’ve seen. None of these, I suggest, are particularly medical in the sense of the MM. Group therapy emphasises not a paternalistic omniscient therapist, but either the adaptive elements on which they can build (DBT skills training) or allowing them to see narcissism from the outside (process-oriented groups).

COP tacks toward finding the narcissist’s praiseworthy qualities and using these to convince the client they needn’t boast or pretend (angeben) here, that they are fully accepted as people and their worth acknowledged. My respondent called this complementary relationship construction (komplementäre Beziehungsgestaltung):

“When the narcissist first wants to display how good they are, you accept that. Right? That means first of all we feed the narcissist, that they get the impression the therapist’s not grinding them down, respects them, acknowledges them. … After some time, the clients also bring in problems. Right? And then they begin to look at the problems step-by-step, what schemas are beneath it, and then you can slowly, so to speak, do analyses. But the first thing we do is always complementary, so treating the clients with acceptance, showing them we accept them, we respect them, we also take it seriously that they’re good and grand. Right? So my experience is that when you don’t do that, you don’t get any trust.”
(DE-CP-6, 25.02.2014)

Goffman (1973), like many theorists of narcissism, suggests that “a basic social coin,
with awe on one side and shame on the other” (70) exists. Complementary relationship construction utilises this to gradually build to the more critical (potentially shaming) elements of therapy. German practitioners often used the phrase “pick up the patient where they are,” of which this seems to be the most extreme form. Some American psychodynamic practitioners used similar expressions (e.g. US-CP-11, 19.05.2014). So far we’ve not seen much of a discrete disease entity, tinkering, or paternalism. What about psychoanalysis?

A psychoanalyst apparently agrees with the COP approach, though he references mirroring rather than *komplementäre Beziehungsgestaltung*. Like the practitioner seeking to find a metatheory for psychotherapy that informs the clinician when to switch methods, DE-CP-5 too focuses on needs. Relationship repair is somewhat paradoxical: stress is chiefly on showing the patient how their self-esteem fluctuations connect to the analyst-analysand relationship. He closed his explanation of the technique with a description of such a scenario: “They simply feel bad, *all of a sudden as it were*, but they do *not* know that it's something to do with the strange look from the [analyst].” Actual rupture repair follows an empathic failure:

“…[T]hose with a grandiose presentation (*Größenselbst*), they need a long-term treatment where I must somehow muster the patience to understand that they want to be mirrored, that they don’t want to be criticised, and when I don’t muster it up, then so to speak the mirror-transference rips and then the therapeutic step is to show the patient step by step that the drop-off in their self-concept (*Selbstgefühl*) is related to this collapse of the transference-relationship, that they recognise these things, can recognise them.” (DE-CP-5, 4.03.2014)

An American psychoanalyst (US-PP-1, 23.05.2013) spoke of “spending a certain amount of time empathising with and even sympathising with his struggles” in an
effort to guide him towards insight regarding the costs of his current *modus vivendi* and the possible benefits of changing this. Empathy is a way of interacting, which can be learned (a point initially made by a respondent, US-CP-3, 2.08.2013). The therapist models it more actively in COP, but it’s inherent even in the analytic encounter.

How they understand the narcissist’s needs leads to certain modes of relating in the consulting room. I fail to see any substantive difference between Kohutian mirroring and “feeding” the narcissist, they appear virtually synonymous. DBT speaks of direct validation (Linehan 1993a:224-225), which bears obvious relation to “complementary relationship construction,” particularly when one regards the treatment of success-less narcissists. “The assumption in DBT is that there a nugget of gold in every cup of sand; … some inherent validity in every response” (Linehan 1993a:224). We return to Freud, every symptom having its sense.

A young American (US-CP-2, 10.05.2013) described TFP’s course, articulating it in terms of interpretations, but the same process operates in cognitive therapies. The series entailed clarification and mirroring early on, “basic interpreting” at mid-phase, and “deeper interpretations or try to expand or deepen the understanding” when “towards the end” of therapy (US-CP-2, 10.05.2013). Overlap is not perfect, but we see a concordance between TFP’s stages and the five phases of COP: (1)

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34 While I could’ve translated Sachse’s “erfolglose Narzissten” as “unsuccessful narcissists,” meaning would’ve been lost. Cheerleading (Linehan 1993a:242-249) is a type of validation whereby “the therapist is validating the inherent ability of the patient to overcome her difficulties and to build a life worth living” (243), and could prove useful in treating these patients who “display practically no real compensatory efforts and therefore also realise no successes” (Sachse et al 2011:12).
complementary relationship construction, (2) development of a work contract
(*Arbeitsauftrag*), (3) clarification, (4) working through schemas, and (5) transfer
(Sachse 2013: Ch. 5).

Most different is transfer, where the patient works on fighting old schemas and
training new ones in everyday life (*ibid*: 74-75). Being heir to CBT, COP
underscores behaviour and practice. TFP patients in the advanced phase, however,
are “bringing in [material], saying, ‘Hey, I noticed this, I think this is what’s going
on, what do you think?’” (US-CP-2, 10.05.2013). Patients are attempting to
generalise insight from the consulting room into their everyday life. In both cases,
new insights (or schemas) are rewarded as they are practiced ‘out there’ – the
difference lies in COP’s encouragement and reinforcement of active behavioural
practice.

Even a more classically psychoanalytic practitioner seems to be in synch with COP.

When asked about competing agendas, he explained that:

“What I’ve found is that when you bring that up too quickly, if you
tell the patient your goals are different from their goals, you tend to
lose the patient. So there’s a certain having to go along and
gradually raise issues about maybe what they’re trying to seek or
trying to accomplish might be part of the problem, and that you
have to do gradually and gently. You kind of have to earn the right
to say that, by maybe helping them with some other things first or
that trusts develops between the two of you to where they can hear
it.” (US-PP-3, 9.05.2013)

At the level of practice, then, there seems to be agreement between ‘antithetical’
therapies.
Practitioners from a variety of theoretical backgrounds advocated role-playing. One particular type, perspective-reversal (*Perspektivenumkehr*) seemed key in teaching empathy\(^{35}\). A systemic therapist (DE-PP-1, 11.03.2014), for instance, described this approach as “working even in couples’ therapy,” stating that narcissists “then become more accessible, softer, and offer more in their relationships with their partners.”

The same approaches were recommended by “a very evidence-based person” (DE-CP-7, 21.02.2014) for use when patients met (and were subjectively disturbed by) the empathy criterion for NPD. Distinguishing the latter clinician are psychoeducative efforts:

> “How does he behave arrogantly, for example, when he enters a group? How does he concretely drive people off? … so what behaviour concretely leads to interpretations by the environment such that he’s perceived as arrogant? And then I can file that down with him. That means that first off gaining the insight that if he keeps behaving this way, that this won’t change and the environment *must* react this way, and I would first concretely explain these dysfunctional interpersonal circles, clarify them so that he understands them and then I would practice with him how to ameliorate it with role-plays.”

(DE-CP-7, 21.02.2014)

ST uses psychoeducation of this stripe as a prelude to role-plays and Gestalt work, particularly with vulnerable narcissists (DE-P-2, 20.12.2013). The second therapeutic technique she recommended for vulnerable narcissists “is that you empathically confront the mode of the distanced protector or the overcompensation mode.” A more integrative psychiatrist suggested that there are a broad range of techniques (role-plays, Gestalt chair exercises, “placing stones”) that can serve this function of “allowing something to come alive and an emotional vibrancy

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\(^{35}\) Interestingly, Ritter et al. (2011) suggest narcissists don’t lack the ability to take the other’s role and understand their thoughts (i.e. they have “cognitive empathy”), but they lack “emotional empathy” (the ability to share in their interlocutor’s feelings). One informant who brought this study up used the verbs *mitfühlen*, *mitleiden*, and *mitfreuen* (DE-CP-3, 22.01.2014). These findings indicate affect-oriented role-play.
A TFP practitioner stressed affect in the interpretation, which similarly relies upon emotional vibrancy. His patient began to have a panic attack when asked about something he enjoyed doing, but calmed down after the suggestion that his anxiety stemmed from the present interaction. After denying this connection again, “then he associated too” (US-P-1. 28.05.2014). My informant then summarised:

“So this led to a very relevant memory, but if I had just said, ‘You know, you told me in the history that you gave me that your father was always critical of you, so maybe now you perceive criticism where it’s not really there.’ That would’ve been, to my mind, a sterile interpretation. It might’ve been right, but when he was feeling anxiety, he was perceiving me as the next incarnation of that critical dad, it had more meaning to the interpretation when we had the raw material.” (28.05.2014)

In our first interview, he gave a more theoretical description when describing TFP more globally:

“So we get to know the internal object as it’s experienced with me, and thereby helping the patients live through different experiences with me of very contradictory natures and being the hovering observer who can draw their attention to the different states which they experience only in pure form. Try to get them to see that these states are all part of a broader whole that they might bring together into a more united fabric. But I always say, in my mind interpretations don’t have much impact unless you’ve got the affect that goes along with the experience that you’re interpreting.” (22.05.2014)

The common tendency is to strike while the affect is hot (e.g. Beck et al. 1985:191-192; James, Morse, & Howarth 2010:88-89; Young 1999:43-44). Since TFP regards splitting as a central problem in borderline personality organisation (and so in their understanding of NPD), there is a focus on integration alongside affect.
Psychodynamic understandings of empathy as a means of relating appear different from their more behavioural brethren. While discussing alliance-building, a TFP clinician remarked:

“But you see when you say to get to the more aggressive interpretations, I don’t think interpretations are aggressive if they’re done with empathy, and we think that the fullest form of empathy is to empathise with everything that makes up the patient’s mind, including what they’re not consciously aware of at that time.” (US-P-1. 28.05.2014)

The therapist here tries to understand why the patient may be feeling aggressive, without condemnation. Modelling of dialectical thinking is, in essence, being done in this moment.

Mirroring aggressive elements can be something of a high-wire act. Technical neutrality is designed to dealing with this trouble, with negative interactional (and thus therapeutic) outcomes if not adhered to. In discussing difficulties he had with narcissistic patients, one therapist sketched such a scenario:

“So we have to deal with a prolonged period, usually, of being criticised, devalued, put down, and tolerate that, not react defensively, not withdraw into a kind of a kind of dismissive state. … we found that some therapists can sort of mirror the patient’s dismissiveness, and then it becomes a stalemate.” (US-P-1. 28.05.2014)

He illustrated this with a personal misstep, the moral of the story being, “[W]e as therapists have to make sure we don’t do what I did in that situation, which was to identify with the part of herself that sees herself as inadequate and then cause all sorts of disruption to therapy.”

All treatment approaches I encountered taught empathy in one way or another. A
more Kohutian approach can be seen in a relational psychodynamic practitioner.

Here it is less modelling dialectical thinking and simply demonstrating the ability to take and understand the role of the other in a situation:

“I think that this is where the restoration of empathy and mentalizing is helpful. As a therapist, you listen, you're trying to understand the nature of a patient's inner [experience]. You don't always get it right, of course, but the fact that you're trying and that you're actively engaging in that process may in itself be therapeutic.”

(CA-CSW-1, 6.09.2013)

Additionally, the therapist here models failure and frustration tolerance, showing that one needn’t be perfect in order to survive. Perhaps this is why the informant went on to explain that “the way in which you have a relationship with a patient constitutes a form of interpretation.”

ST is already “thoughtfully distributed, not eclectic” (US-LCSW-1, 16.09.2013), but a pure practitioner in Germany tended very much towards amalgamation. He borrowed elements from DBT and COP, with the distinction that in *komplementäre Beziehungsgestaltung*, “the more I do this, always try to come more onto traits that aren’t status-oriented” (DE-PP-2, 3.02.2014). Though we might expect this blending of therapies sharing a progenitor, he also referred to a “power struggle” (*Alphakampf*) that could periodically emerge early in therapy with narcissists. This can be accomplished through quick-wittedness (*Schlagfertigkeit*) or humour, as opposed to rigorous, psychodynamic interpretation. After the power struggle and winning the patient’s trust, he states that:

“You have to open yourself up very, very much in that moment. But that’s true of all [PDs]. You can never treat [PDs] technically. … With [PDs], you have to involve a lot of your self (*Person*). That means I’ve always got to check, ‘How can I say this so it’s even more truthful (*noch echter ist*)?’ … I believe that’s the level
This clinician closes with confrontation, which looks rather unlike the psychoanalytic technique of the same name. Each aspect of the self has a figure, “Denise [a stuffed alligator] represents the narcissistic side, for example.” The technical trick is the same, however: “You can distract yourself, saying, ‘How often did Denise come this week?’ and thereby they can establish a distance so that it’s no longer experienced as so ego-syntonic.” The goal is to make the familiar foreign, thus facilitating change, as he suggests: “At the very end, you go into behavioural change, that works through schema memo cards” (DE-PP-2, 3.02.2014). Conceptualisation offers specific tools for self-distancing and becoming more empathic.

All models did this, but different approaches provided diverse tools. I asked a respondent if how one understood narcissism could somehow influence the treatment. This query led to some confirmation of my basic perspective:

"Not just somehow, rather how you receive narcissism (wie man Narzissmus rezipiert) matters a lot and also how you grasp and can respond to it in the current [i.e. treatment] situation."

(DE-P-10, 21.03.2014)

We see here a weak example of what I teasingly term psychotherapy slogans which emerge from the Ansatz and guide practice. These so-called slogans crudely chart the psychotherapeutic interaction’s course.

An American schema therapist gave a much more in-your-face illustration. I asked how she balanced limit-setting and self-disclosure with the need to create a safe environment for the patient. As with her analytic colleague above, we find
indication of Ansatz as astrolabe:

“The rule in self-disclosure in [ST] is always remembering to ask yourself the question, ‘What would a healthy parent do in this situation?’ … That’s the question that helps inform how much self-disclosure, when to set the limits, when to allow anger to flow, when to be more empathic with your confrontation.”
(US-LCSW-1, 16.09.2013)

ST’s strategy can therefore be overly simplified as “What would a healthy parent do?” Rafaeli et. al (2011) lend further confirmation: “Limited reparenting…is a guiding therapeutic stance – a broad approach to the therapist’s role” (155). The informant, however, also left some aspects unclear. She described her choice of interventions as follows:

“How strong the mode might be at any given time they’re in treatment. If they come in in a very detached state, without emotion and not willing to look at emotions, become defiantly unwilling and defensive or non-complaint, sometimes it’s helpful… We use whatever is going to help break through that barrier, because I always want to be able to make contact with the vulnerable side and with the healthy adult.”
(US-LCSW-1, 16.09.2013)

As the above quote indicates, shame and blame loom large in treating NPD or pathological narcissism. Clinicians may misattribute credit, or camouflage or adopt culpability through interactional techniques I dub masking mechanisms. A clinical social worker asked his patients (narcissistic and not) how they explained therapeutic successes, and what they might’ve missed in his work which could explain why something wasn’t achieved (paraphrase, DE-PP-1, 11.03.2014). He clarified that “by setting this question, I give them the chance so to speak to stabilise their self-esteem at the end of therapy also.” The same practitioner depicted how these masking mechanisms operate in the day-to-day of psychotherapy:

“I attend to not irritating the narcissist, to avoid the strong narcissistic competition that settles in easily. So there I notice that
I’m on the spot and in every formulation, to be sure. When I have an idea it’s practical to formulate it very carefully so that they don’t feel pressured to devalue it. So when I have an idea that they didn’t come up with on their own, then I say something like: ‘Well, this doesn’t have to make sense to you immediately’ or ‘I can imagine that you’re not too thrilled by this idea’ so that they don’t have to feel stress to keep their sense of self-esteem on a level basis, and they feel less threatened, yeah?’

(DE-PP-1, 11.03.2014)

A TFP practitioner (US-CP-6, 7.06.2013) described a virtually identical approach.

Such a similarity could be explained away by them reading the same texts. The pure practitioner, however, somewhat embarrassedly confessed that, “I mean, I think I have not yet read anything proper about narcissism.”

An equally ‘non-technical’ (and non-MM) approach to not shaming the narcissistic patient can be found with an American psychoanalyst. His method is more to build solidarity by blaming circumstance or pointing out the faults of a third party:

“I sometimes use humour, but you have to be careful what kind of humour. You can’t tease or poke fun at the patient. They’re sensitive. But you can use humour like the foibles and imperfections of life out there to sort of say, ‘Isn’t it something how that never works out?’ or how they screw up or something like that. Even where somebody does some kind of a humiliating or slighting thing, you can say, ‘Boy, that was a sweetheart,’ or something like that.” (US-PP-3, 9.05.2013)

Not quite a masking mechanism, but related is “object-centred interpretation.” The therapist again models behaviour, but not by directing admitting fault (as in DBT). A psychiatrist described grandiosity as “usually defending against a sense of inadequacy,” and that in therapy the narcissist must “get in touch with” that “extremely painful state” (US-P-1, 22.05.2014). He then outlined how he sometimes does so:

“So in order to help the person to get in touch with the negative
elements of their internal world, which of course we all have, I have found that it’s helpful to use a technique that I’m sure is broadly used, but the best initial description of it that I know is in John Steiner, what he referred to as analyst-centred interpretations, which now since we mostly don’t do analysis we call therapist or object-centred interpretation, which is observing the devalued object as it’s seen in you, with the idea that the person couldn’t tolerate observing it in themselves but if they observe it in you and you don’t collapse, this flaw is kind of an object of wonderment for them. They can’t quite figure out how a flawed object could continue to exist and function.” (22.05.2014)

A clinical example was then capped by the following summary, which demonstrates both amalgamation and segregation:

“I say, ‘Ok, I’m not perfect, but I’m still here and talking and living and breathing.’ I didn’t say it like that but that’s kind of what I was saying. And I think that begins to help somebody see that survival doesn’t depend on the grandiosity. Of course it’s a defence from thinking that nothing genuine can happen, and even though I’m not a relationalist in the full sense of the word, I think that as you skilfully manage the intensely negative transference, you show all relations don’t turn on a superior-inferior axis, that the patient begins to experience an interpersonal gratification with you that’s maybe unknown to them. They might think that might be a reasonable alternative to being isolated in their own sense of grandiosity.” (US-P-1. 22.05.2014)

On the one hand he isolates himself (“not a relationist…”) while simultaneously adopting a more strictly Kleinian method. This TFP clinician refers to sight and demonstration, which – combined – hint at this modelling function.

A CBT clinician (US-CP-3, 2.08.2013) explained narcissists “generally don’t seek therapy voluntarily,” leading him to ask “why they’re there.” He then ‘feeds’ the narcissist in a less direct manner:

“[W]hat I do is ask the question, ‘Would you like to get more of what you want?’ Which is a very intriguing notion to narcissists. And they're usually taken aback by that, Carl, because what they're expecting is, they've been sent to therapy for me to take them
down. To show them that they have dirty feet. And what I do is say, ‘Tell me what you like and let me help you get more of it.’ So you want to be noticed, great, I can help you with that. You want greater recognition, super, I can help you with that. And then work with them on developing pro-social ways of doing it.”

(US-CP-3, 2.08.2013)

The practitioner aligns himself with patients by conceptualising therapy as self-optimisation, and describing himself as a “personal consultant.” Collusion triggers curiosity: this singular set-up circumvents shame by appealing to the narcissist’s interests, thereby engaging the patient and creating motivation to change.

“[N]arcissists are great at using people, so I want to speak their language” (US-CP-3). We see not only translation, but also the enrolment of patient strengths. He demonstrates great awareness of how this approach might be perceived: “Now have I made him a better narcissist, or am I instructing him in pro-social behaviour? You can call it either way” (US-CP-3, 2.08.2013). Ultimately, this move is pragmatic, showing CBT’s bias towards problem-solving, the everyday, the immediate.

This bias towards the here-and-now is generic to all therapies I encountered. We see the narcissism of minor differences at work again, and not obscuring the MM. Psychodynamic practitioners most explicitly expressed this idea. One analyst explained that narcissists (“in any case those that I take on”) are often intelligent (a point echoed without the statement about selection by DE-P-10, 21.03.2014), creating a need for extreme acuity in the interaction:

“With a neurotic patient you can, already even in the assessment (Vorgesprächen), lean back a bit while in my experience you yourself must be very quick with a narcissistic patient, and interpret the transference and countertransference on the current surface, in the session’s current matrix – thus on minutia.”
(DE-P-12, 17.02.2014)

He explains that “descriptive interpretations, close to the affect, close to the feeling, not theoretical things” are called for with such patients.

Virtually any more orthodox TFP practitioners and the single Kleinian I spoke with (DE-P-8) would agree. I asked a more manual-oriented clinician (CH-P-2, 20.02.2014) about his opinion on whether or not a clinician could use relapse prevention methods to prevent narcissistic individuals from ‘relapsing’ into exploiting others. He explained that two concerns were central here: first, that being antisocial isn’t something present or absent, “rather there are traits (Anteile)”, and that the capacity for empathy determines if such an approach could be helpful. Should patients find it sensible to do so, an opportunity arises to work on this aggression which the patients don’t recognise in themselves:

“[CFD:] And you do that using the therapeutic relationship as an example of how it could be for the patient outside of therapy?

Naturally when you interpret things in the transference, it’s not always actually the case that the material’s there. But at the outset it can be helpful, outside relationships, for example, or experiences that they then describe, … And that we then say, ‘Yeah, how did you feel then?’ That’s a little bit of the mentalization thing that you say, ’When you dealt with the other person like that, they felt a little bit exploited or saw it that way.’ And then you can work on it directly without it coming from the relationship. Sometimes then I bring an additional example from the relationship, one that’s similar.” (CH-P-2, 20.02.2014)

The therapy relationship is backgrounded to stress real world connections. Such a move is strategic in that doesn’t confront the patient with the reality of the therapeutic tie, but reduces it to another point of evidence. Commitment is initially downplayed, a strategy also recommended by a more classic analyst (DE-P-12,
17.02.2014). Even ST’s mode work, ostensibly past-oriented, provides clinicians a way of interpreting the unfolding interaction moment-by-moment. The “genetic” component is important because it allows the patient to distance themselves from the mode, while also offering clinicians tools to cope with clients’ current behaviour.

Chain analysis in DBT (US-CP-10, 15.08.2013) similarly forces the patient to step back by essentially making them an autoethnographer detailing the events inside themselves and in their environment. Extra-transferential interpretations similarly link affect and action in the real world, but are seen as a “modification” of TFP as done with BPD patients (US-CP-6, 7.06.2013).

Chain analyses (see Rafaeli et al. 2011:117-118 on these in ST) and extra-transferential interpretations help patients to see destructive patterns and their causes, expediting the process of generalising new behaviours learned in therapy. The CBT family of therapies utilises homework to help patients implement new behavioural strategies. All schools in this tradition have some way of ‘extending’ the consulting room into the outside environment. Flash cards in ST (Young et al. 2003:104-107, 162-163, 171; also audio flash cards, US-LCSW-1, 16.09.2013), phone calls in DBT (Linehan 1993a:188-191, 497-504; though see Yeomans et al. 2015:110-112 on emergency calls in TFP), and homework across all CBT-lineage therapies (cf. Beck et al. 1979: Ch. 13).

Self-distancing is a common feature of all the therapies I studied. Dysfunctional thoughts and underlying assumptions are CBT and COP’s relevant intellectual

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Interpretations of events occurring external to the transference relationship between therapist and patient, i.e. outside the consulting room. A more classic psychoanalyst referred to the same technique though not by name (US-PP, 9.05.2013).
interpersonal therapy generates intrapsychic distancing by explaining that once-adaptive behaviours have become fossilised and are now maladaptive. By siting the conflict inside patients, TFP and psychodynamic therapies encourage reflection, which requires some remove. The ‘observing ego’ concretely conceptualises this distancing. TFP’s emphasis on object relations gives patients a means of tying together what were previously disjointed emotions and experiences.

ST has commonalities with many of these theories and admits the influence of others. Early maladaptive schema give patients a language for making familiar forms of thought foreign. Schema modes, or “the moment-to-moment emotional states and coping responses – adaptive and maladaptive – that we all experience” (Young et al. 2003:37), use time to distance the individual from those maladaptive parts of oneself. Additionally, ST practitioners themselves note “we speak of a mode as if it were a person … because it helps patients distance from and observe each mode” (ibid: 333; cf. 342-345). In short, all these therapies provide a language for metathought. Davies (2009:98-100) is correct in asserting that psychodynamic therapy conveys a means for imagining one’s internal world, but it isn’t alone. The theoretical terms which the patient is taught alone generate a gap, but all of these methods continue to stress the difference.

DBT is a possible exception to this metathought rule, due to its extreme behavioural orientation. Environmental action seems far from thought: “I try to operationalise the symptoms as behaviourally as possible” (US-CP-10, 15.08.2013). This systematic breakdown into units of behaviour gives the patient a means for making
sense of their actions. As the core of the skills training teaches patients dialectical thinking, I argue DBT inculcates a form of metathought. Berger and Luckmann (1967) elaborate how this vocabulary of metathought might work:

“Language is capable not only of constructing symbols that are highly abstracted from everyday experience, but also of ‘bringing back’ these symbols and appresenting them as objectively real elements in everyday life.” (40)

As I apply their argument (ibid:Chapter I.3, especially 36-41), shared language concretises and orders the patient’s experience in a common medium. Thus it ratifies not only their experience, but also their very humanity.

Distancing also occurs through mundane mechanisms. Most obvious is metaphor (Ferrara 1994:129), which does so by “approximat[ing] the truth”, “approach[ing] it obliquely” (131). Urged repeating is an intervention where a patient is asked to repeat a phrase or behaviour “[t]o explore and expand awareness of [their] actions” (ibid:126). By pausing and redirecting the patient’s attention momentarily to the act, reflection is encouraged (ibid). Group therapy provides opportunities to see differently, to identify with another person (Young 1995:214-217). Seeing an attribute in others can suddenly transform or give a n, according to one German (DE-P-4, 4.02.2014): "So when you treat in a group like that, others report from their life experiences and suddenly it hits, 'Yeah, man, it was like that for me too!'" While group therapy builds the relational boundary with patients, in one-on-one psychotherapy this cannot be done. How do models help the clinician bound an intense, affect-laden relationship between patient and practitioner?

**(I.3) Frames and Contracts: Bounding the Relationship**
Another common factor across all psychotherapies I studied was what psychodynamic practitioners referred to as “treatment frames,” and others as contracts. Others define this more in terms of overarching treatment goals, rather than a frame. There are then varying degrees of formality. One integrative psychiatrist explained that following a thorough assessment of what problems the patient has and what strengths and resources they have, he then makes a treatment recommendation and they work together to define therapy goals:

“We do it such that we set three goals, so we identify the underlying problem and then what should change. … And I’d also retain this goal as long as there’s no reason to abandon it or replace it with another goal. The danger in psychotherapy is always that patients say a lot, that a lot happens in everyday life, and that then you work through a different difficulty (Problematik) in every session and not concentrating on a single goal, and I exactingly explain this, why it’s important to have a good plan, that you can still change it when necessary, but that therapy consists of adopting a work plan (Arbeitsprogramm) and then work it step by step.”

(DE-P-9, 12.03.2014)

A frame or contract provides a ceremonial superstructure for psychotherapy, and allows a more cumulative focus. It can channel the treatment and avoid the long process of cutting a riverbed through bedrock. Neither patient nor practitioner has to struggle with anomie. In some sense, the frame “endows the space with security” (Davies 2009:66-67). Sulzer (2012:50), studying clinicians who treat BPD, found the opposite. She quotes an informant about being BPD patients feeling insulted by “rigid conditions” and “rigid judgments about their behaviour” and then gives the following expansion:

“Rigid conditions can include policies such as prohibiting a patient from calling after-hours, strict attendance policies with no room for sickness or work obligations, and asking patients to sign contracts which detail appropriate care practices that the patients deem to be overly invasive or infantilizing, and are not administered to other groups of patients.” (Sulzer 2012:50)
Sulzer provides absolutely no documentation for this assertion, despite having interviewed “10 persons with [BPD] or Difficulty Regulating Emotions” (123). She does not, however, engage deeply with the clinical literature on BPD, which biases her finding. In contrast, Young (1995:193-197) points to two incidents where overly rigid and minor modifications to limits led to problems in a PTSD clinic.

A respondent who was a fairly strict TFP adherent described virtually the same procedure, but offered some additional reasons why a “frame” or “treatment goals” were essential:

“I'm very big on setting a frame with the patient, being explicit about that frame, not assuming that they've been in other treatments so they know how psychotherapy works, or anything like that, but with the idea that you have to be explicit, for a number of reasons. One, you can't assume that people understand the frame that you're providing. Second, if there's deviations from that frame, if you've been explicit about it, you can actually then talk about those deviations in the context of the frame. I think the frame also sets up an environment where you feel safe as a therapist and where the patient feels safe to talk about what comes to mind as a patient.”

(US-CP-6, 7.06.2013)

The TFP manual explicitly states that the frame serves to “[d]efine the reality of the treatment relationship” (Yeomans et al. 2015:101) and allows the therapist something against which to check their countertransference (101, 133-35, 176). Over and above this, the frame follows from the conceptualisation and serves to further induct the pre-patient into the role of patient. It does this by informing them of “the rules of the game” (US-P-1, 28.05.2014), and what they can realistically expect out of therapy. An excerpt from a DBT therapist’s answer to a question about balancing boundaries and collaboration is here illustrative:

“When you talk about the contract, it’s not really done in
pejorative, demeaning way. I think the clients find it kind of refreshing to have the person be like, ‘Ok, here’s our very clear expectation of what’s going to happen, and you’re going to help me develop this very clear expectation.’” (US-CP-10, 15.08.2013)

“The therapist’s very professionalism is closely studied ensuring the performance of a specific set of relational behaviours that are consistent with the theory” (Davies 2009:73). More strictly psychoanalytic practitioners stress more that the frame “have the abstinence or the anonymity” (US-PP-2, 17.05.2013). In a way, however, this is the mirror image of DBT’s “personal limits,” because even in analysis there is a tacit understanding that the boundaries in psychotherapy are flexible and highly individual: “Therapists struggle with how much to relax their own frames, and I generally don’t, but I think other therapists do and they may then keep patients in therapy longer over these hurdles” (US-PP-2, 17.05.2013). The range of formality runs from more classical psychoanalytic and Kleinian approaches (“no contracts, no sanctions”, DE-P-8, 6.05.2014) to TFP and DBT on the other end. CBT, COP, and interpersonal therapy seem to sit somewhere in the middle. But given that more often than not these frames or contracts are negotiated, we can see similarities, but not in what sociologists call the MM.

As the CA literature earlier implied, psychotherapy is a form of institutional talk with certain aims. We’ve looked a good deal at the commonalities across treatments, particularly how conceptualisation frames the patient-clinician tie. Do practitioners see these likenesses? Or do they see difference, but a path towards integration? We turn to this now.

(I.4) How do Practitioners Prioritise Targets?
Four practitioners suggested that there are two broad goals in psychotherapy with narcissists. One clinician described what he thought a gold standard treatment for NPD would look like:

“I would have to find a systematic way of confronting grandiosity and teaching empathy. I think those would be the essential elements. So I’m thinking of something probably less psychodynamic and more cognitive, although I think the best therapies use both methods. ... But there must be a way to get some of these ideas across without people just going into a rage. So we need kind of a structure and a plan to do that. And also the other half, the empathy part, I think narcissists just don’t know what other people are feeling. So there’s kind of a teaching element that has to be put into therapy about this.”  

(CA-P-1, 21.08.2013)

The social-personality psychologist I interviewed had quite similar ideas, but referred to “responsibility taking” rather than “confronting grandiosity,” and used “communal activation” to encapsulate empathy training (US-SPP-1, 26.05.2014). He suggested that more neurotic (in five-factor terms) patients would likely benefit from “[the] mindfulness group of therapies that deal with the reactivity.” Overall, he indicated that, in his reading of the literature, treatment was successful if one could clear the hurdles of motivation and retention: “There’s no treatment that doesn’t work. They seem to work if they get people in them.”

One Germanophone offered a modular therapeutic model, whereby parts could be imported from other existent methods and grafted in as needed:

“But I think important methods are reflection, read mirroring, mirroring of their behavioural patterns (Verhaltensweisen). Self-esteem work, empathy training so that they learn how to put themselves in others’ shoes (lernt sich in andere hinein zu fühlen) are also important methods. And I think, however unscientific this may be, with narcissism, so to speak, humour is also something very important, so to say the ability to laugh (Lachenkönnen) about negative behavioural patterns, that thereby one gains a smidge of
Again, the idea is to render the familiar foreign, which can be done through humour.

This respondent had also stressed that a great deal was dependent on “who learned which technique.”

One of these practitioners made education still more essential in his account, stressing that this broadened the proto-clinician’s perspective and also prepared them to deal with the emotional responses they had to these patients. It was not just a matter of research (e.g. from developmental psychology) influencing treatment:

“Then it’s such that often frequently that the treater’s capacity is insufficient for this disorder, and that the people then still get irritated (gekränkt) or feel small (erniedrigt) or somehow don’t see the extraordinary fragility (Verwundbarkeit), for example when they cause a big row and it’s really very hard. That’s less something that one can work through in research, rather that must be trained, very good supervision must be [put] in place.”

(DE-P-10, 21.03.2014)

There is a split between clinic and laboratory, experiment and experience.

Sometimes this might be expressed as jealousy, as when one medical researcher said, “You can publish far more on far less information” (Atkinson et al. 1998:277).

Whooley (2014) sees Research Domain Criteria37 (RDoC) as widening this split by “decoupling” psychiatric research from the DSM (102-104). This act and the supposed “brain-centrism” of RDoC (104-106) he takes to further decontextualize mental illness. Sometimes information will not only be not yet applicable clinically,

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37 The Research Domain Criteria are a matrix outlining broad areas of function, mainly to be studied at the level of “neural circuitry, with levels of analysis progressing in one of two directions: upwards from measures of circuitry function to clinically relevant variation, or downwards to the genetic and molecular/cellular factors that ultimately influence such function” (Insel et al. 2010:749). While one underlying assumption is that “mental disorders can be addressed as disorders of brain circuits” (ibid), I believe calling it brain-centric misses the increased focus on multicausality.
other times “therapeutically-nihilist and reductionist assertions of a linear
deterministic relationship between brain, personality and behaviour” are made
(Pickersgill 2011b:459).

The informant (DE-P-10) portrays the psychotherapist as a guide, showing the
patient other ways are possible. While this clinician later states that he has not come
up with specific interventions to introduce such alternatives, he offers some general
advice on how to deal with narcissistic patients:

“Working with interpretations is often not called for. There it’s
something completely different. There it’s about, for example,
possibilities, alternative pathways of self-esteem regulation and
affect regulation, and there it’s about more calmly tolerating their
own often extremely intense internal commentary.” (DE-P-10,
21.03.2014)

What this psychiatrist proposes is an active engagement with the patient. Another
German (DE-P-9, 12.03.2014) offered a very similar guideline, opining that therapy
should move “maybe even more in the direction of a coaching-relationship.”

His caution about interpretation (DE-P-10, 21.03.2014) represents a more Kohutian
approach to narcissists, but the whole tone of his remarks here feels behavioural.
Some confirmation of this can be found in his later technical suggestion that if
trauma is present, patients react well to “calming exercises (Stabilisierungsübungen)
or some other type of training like DBT.” Amalgamation is here apparently
operative, but such boundary-blurring is not always well tolerated.

An incident from the 2014 NASSPD banquet here is illustrative of the importance of
conceptual/methodological purity to some practitioners. I was speaking with a
young clinician just beginning her DBT training, and I told her that I had seen DBT described as a psychodynamic therapy in a course syllabus. She grew indignant, saying something like, ‘No, it’s not. A lot of therapies take stuff from DBT, but that’s not DBT.’ This misremembrance – the syllabus described it as another principle-driven psychotherapy – proved fortuitous in revealing this need to guard the boundaries of one’s therapy, especially as an initiate.

One informant flagged some subtle distinctions between three psychodynamic approaches to narcissism: mentalization-based treatment, Kohut’s self-psychology, and TFP. He states:

“So in the narcissistic patient, I look for what’s irritated them, what’s brought them out of balance (Gleichgewicht)? From where does the need to be critical of me emerge? This has very strongly encouraged the self-psychological school and also Fonagy and others or also the interpersonal school of psychotherapy to admit their own mistakes with narcissistic patients. For example, to say, ‘Yes, I’m sorry, I in fact didn’t prepare your seat very nicely. I understand that now you don’t feel very good here.’ You would not do that in a Kernbergian orientation. When you’ve really made a mistake, you would say that, it’s true, and you would here say to them, ‘I understand it bothers you. You would prefer that everything has been prepared just so (genau ordentlich), that you get the feeling you’re welcome and when it’s not so, you slide into doubt whether you’re welcome here, and let me feel (spüren) that through a certain critical type of observing and inquiring.’ That means I also reflect to them, if you please, their destructive demeanour, but I connect it with an internal worry, irritation, anxiety, and thereby it is more easily absorbable (aufnehmbar) for the patient.”

(DE-CP-4, 12.03.2014)

The (perceived) difference between these treatments is interactional: relational ruptures or interpersonal conflicts between therapist and patient are handled with what appear to be subtle distinctions. A more deferential apology, like something we might see between friends, is (in this portrayal) is taken as typical of these other
schools. In his example of a Kernbergian repair, there is a measure of cognitive empathy (“I understand”), but not an outright admission of fault. The hostility is pointed up by the TFP practitioner, so that it can be connected to internal states. Topicalizing an external conflict and linking it with an internal one is a means of generating distance between the patient and their symptoms. By siting it conversationally, the therapist here concretises the patient’s problems without any ethical valuation. It is not that the TFP clinician has no regard for the patient’s emotions or the integrity of the therapeutic alliance, but rather that the ‘apology’ is here used with more long-term aims. Mentalization-based and self-psychological apologies are, in this telling, more myopic\(^\text{38}\). Though the more Kernbergian repair is more cognitive, there is not a sense of the perfect therapist who cannot admit fault. I see this as contradicting the standard sociological MM.

Standardised diagnosis ought to lead to interventions keyed to specific disorders – this connection seems to me to be irrefutably medical. And to some extent, psychotherapy has attempted to do just this, although more successfully in some areas than others. I’ve argued that there are more similarities than differences between the theoretical traditions, but these don’t fit with the MM. We are back to the paradox that opened this chapter: how the various schools say they relate to that malfeasant MM.

(II) Physical Treatments, or Banishing the Biomedical Bogeyman

Modern psychiatry is biopsychiatry, and biopsychiatry means pharmaceuticals runs

\(^{38}\) I don’t wish to lay undue weight on this evidence.
the medical sociologist’s mantra. I begin for this reason with physical treatments, as these can speak directly to a biomedical model. With the ubiquity of psychopharmaceuticals in modern psychiatric practice, the shock is less that a practitioner mentioned them and more his identity. A psychodynamic practitioner described it as follows:

‘Psychotropic medications are an auxiliary treatment. Speaking in very general terms, he said there was about a 30% response rate, but that narcissistic patients tended to change medications frequently. Their use was, in his opinion, questionable as patients would often attribute the changes he felt psychotherapy brought about to the medication, and they would sometimes drop out as a result.’ (US-P-3, 25.06.2013, fieldnotes)

When I asked a more biologically-oriented psychiatrist about this figure, a great deal of clarification was necessary. We agreed that the medication was for comorbid conditions in patients meeting NPD criteria, which led to his elaboration:

“So when [NPD] patients get depressed because of a narcissistic injury, for example, sometimes that depression may have some of the neurobiologic substrates that make it conducive to treatment with an antidepressant. But sometimes they don’t lead to that kind of thing. If it’s narcissistic injury, it doesn’t necessarily respond to an antidepressant. Any patient, any one of us suffers and feels bad if the narcissistic injury might not respond to an antidepressant, if that’s what you’re talking about. But some of them do develop depressions, and they have to be distinguishable from a biologic vantage point to go back to antidepressant responsive depressions. It depends on the individual, the duration, you know the whole thing.” (US-P-2, 11.07.2014)

A standard sociological reading would refer to the tautological reasoning inherent in this physician’s account. I argue, however, that this demonstrates an understanding of what Hacking (2001) called biolooping. He describes the body and mind as a feedback system, wherein “[c]hanges in our ideas may change our physiological states” (109). What happens here is that changes in the mind brought on by narcissistic injury can lead to changes in the brain. The partial list of depressogenic
assumptions in Beck et al. (1979:246) includes many items which bring narcissism to mind. Particularly pertinent is this last one: “My value as a person depends on what others think of me” (ibid).

The converse kind of biolooping can be seen in Wilhelm Reich and Alexander Lowen’s bioenergetic techniques, although these are seen as less scientific and therefore less prestigious. Psychological strains can be expressed in the body, and be relieved through different types of “body work”, including massage. One of my informants used such methods:

“Because this tension, this irritation, ‘I’m not good enough,’ then also manifests itself bodily above all in muscle tension. When you activate that and give it a release, usually a release of aggression. Then the people relax much better, they emerge out of this aggression blockage (Aggressionstau), and they gain insight. So the courage grows to know how they developed, what was wrong with their parents that they weren’t sufficiently capable of love.”

(DE-P-4, 4.02.2014)

While such methods struck me as strange, there is no reason these could not be scientifically investigated. Linehan (1993a: 346-347,356-357) recommends if a primary emotion (e.g. anger, rather than shame about anger) is to be reduced, borderline patients can express an opposite emotion. Here the body is used to change the mind as well, and this is a well-regarded therapy with an impressive evidence base. What seems to be at issue is that the Reich/Lowen technique fits neither with norms of science nor those of society. The possibility exists that bioenergetic massages cause a placebo effect, which then facilitates further psychotherapy.

DE-P-4 suggested that these methods sometimes brought about intense affect, either in form of tears or aggression. While other techniques have been developed by
psychodynamic clinicians (Kernberg 2004: Ch. 14) to deal with such situations, he
had a fairly low-tech solution:

“In the clinic we had a heavy bag (*Lumpensack*), that one could hit
or kick, because naturally these are affects that one can’t
experience in the relationship. These are, shall we say, murderous
impulses (CFD laughs) that you can’t tolerate in the transference.
But against such a heavy bag one can have a true affect storm, and
then one can speak about it so that we can now integrate it.”
(DE-P-4, 4.02.2014)

I am uncertain of the precise impact, but it must be mentioned that this process of
letting the affect storm play out was used in an East German clinic. My sense,
however, is that this clinician’s adoption of a bioenergetics model led to this physical
solution more so than the national context. If aggression, so to speak, can be held in
the body and released by massage, then it stands to reason that other physical
expressions of the emotion can be cathartic for the patient. The biomedical model
calls for a tinkering relationship, whereby diseases are purely manifestations of
bodily ills. Physical treatments for NPD used by my informants – even a
biologically-oriented psychiatrist – all accounted for psychological and
developmental (i.e. social) factors. We can safely rule out the biomedical model.

How, then, do psychotherapeutic schools describe their relationship to the MM?
What is the medical model morass?

(III) The Medical Model Morass

None of the therapies I studied claimed to adopt a MM of mental illness, and several
explicitly denied it. In my interviews, one German psychoanalyst (DE-P-11,
5.03.2014) explicitly referred to “repairing” and that he had problems with the notion
you could fix the psyche. An excerpt from my field notes shows both amalgamation
and the complex relationship between the medical model and psychotherapy:
‘[CFD:] How do you treat a narcissistic patient? In the classical psychoanalytic way, on the couch, or sitting opposite, or…? Respondent complains (but very friendly, still warm) that I’m almost adopting this repair-model. “With both…” Even when you don’t work with the couch, you pull in things from the intensive couch situation. You can’t give any universal answers, how you treat narcissists in general. It’s about individual people.’

(DE-P-11, 5.03.2014, fieldnotes)

Later in the interview, he returned to this notion of what I called the defect- or repair-model of mental illness. This mention came in the context of a broader question about the relationship between clinical experience and scientific understanding. He (DE-P-11, 5.03.2014, field notes) suggests an interesting comparison, saying, “I’m a medic you know… [Clinical] psychologists are now more medical than the medics.”

Using the MM is less a question of theoretical orientation, and more of professional standing in this account. There is an implicit sociological analysis here, whereby the younger (therefore, theoretically less stable in terms of prestige) occupation feels a need to lean more heavily upon the MM, and therefore on science. Science carries a huge weight in modern Western societies, both morally and in terms of status. Without an extensive tradition to invoke and a need to insure that their professional is not marginalised, turning towards scientific or evidence-based treatment is a safe move. Perhaps in light of this we can better understand the contrast between various treatment manuals and clinical texts which refer to the MM.

Outright rejection can be found in Linehan (1993a:390): “DBT is not based on a [MM] and actively works against a quasi-parental relationship, or one that treats the patient as a child.” Given her focus on dialectics, it should shock exactly no one that
Linehan simultaneously acknowledges that there is a need to preclude “reciprocal vulnerability and disclosure” (*ibid*). Somewhat more confusing is Kohut (1971:2-3), who poses questions about diagnosis and treatment of narcissistic disorders, then immediately defends himself:

“...my approach to psychopathology is guided by a depth-psychological orientation which does not lead me toward looking at clinical phenomena according to the traditional [MM], i.e., as disease entities or pathological syndromes which are to be diagnosed and differentiated on the basis of behavioural criteria.”

The rejection of “clinical phenomena… as… pathological syndromes” is antithetical to any sort of “approach to psychopathology,” and constitutes a contradiction in terms.

Rejections of the MM were not limited to treatment manuals alone. One informant explained that he was afraid that "ever more is being pathologised," and pointed to the DSM's growth over time:

"But that's a narcissistic phenomenon too. Everything that's somehow uncommon gets declared a disease. That means you've got to sweep it out of the world, and that then means therapy."  

(DE-P-3, 14.01.2014)

Other informants (e.g. A-P-2; DE-P-7) made similar remarks, and one (DE-CP-5, 4.03.2014) went so far as to say, "I believe that is a marketing policy (*Marketing-Politik*), we just need to declare enough people sick, then our profession will flourish."

The TFP denial of the MM is perhaps the most conceptually puzzling. With its focus on precise diagnosis and frequent discussions of prognosis, Kernberg’s approach ‘smells’ distinctly medical. Yeomans and colleagues (2015) mention the MM only
in the context of “medicolegal concerns” (281-283). The “[MM] approach to issues of responsibility in which a professional who has accepted a patient into his or her care takes responsibility to save that person, while the patient is seen as the passive recipient of treatment” (282) is rejected both to preclude “secondary gain” and TFP’s efforts to build the patient’s autonomy. Most telling is the footnote to the section quoted above: “Even this [MM], as described here, does not apply in most medical interactions – short of a patient’s being unconscious or under anaesthesia – because the patient’s active cooperation with treatment recommendations is important in most treatment situations” (282n1).

One clinician said he didn’t view his own work as scientific, but nevertheless he endorses the (minimal) medical model:

"We had something like 15,000 patients in the clinic in some 30 years, and that which I've written about is basically experiential knowledge (Erfahrungswissen), so how does the disorder present, what causes it, and how are the therapeutic odds?" (DE-P-4, 4.02.2014)

Presentation, aetiology, and prognosis form the backbone of this individual’s understanding.

One informant expressly endorsed a variant of MM:

“[W]hen you go in to a doctor, they do a whole review of systems and you may choose to focus on one particular system that's giving you a problem at a particular time, but that doesn't mean that you don't have all these other things going on. And then when they do some lab work, it's not like they get one answer back, say you get blood work, you'll get a whole slew of blood profiles or a liver work-up or something, they'll give you five or six different indices and it's that profile that then begins to tell them how they might want to approach treatment, and I think [if] we think of mental disorders similarly, we'd make a lot more progress.”
What she proposes for psychiatry is a systems-oriented, dimensional disease model, rather than the present DSM approach which generates artificial cleavages in the pursuit of specific, mechanism-oriented diseases (cf. Rosenberg 2015:133).

In another episode of odd bedfellows, a French-trained psychoanalyst proposed a similar model. I asked him whether we could understand pathological narcissism as a disorder of boundaries (Grenzstörung) and was swiftly shot down. He (DE-P-7, 13.02.2014) explained that narcissism was an “intrapsychic constellation” which could lead to symptoms when fragile. Symptoms are both situation- and individual-dependent, and, furthermore, his view was incompatible with a “purely diagnostic classification” because he “also observes the interaction between symptom, environment, and intrapsychic response potentials (Reaktionsmöglichkeiten).”

He went on to reject the disease – but not medical – model:

“That works only on the basis of biopsychosomatic disease model (Krankheitsverständnis), so where illness isn't the outcome of some evil toxin (Noxe) encountering an actually healthy person rather that healthiness is a range (Schwingungsbereich) which people move in, whose swings don’t go over into illness. Illness is in this sense an outcome of what resources a person has against the inflow of internal and external stressors they meet, and not just a toxin attacking an otherwise actually healthy person.” (DE-P-7, 13.02.2014)

Note that we still have a course and an aetiology, though here mental illness is overdetermined. There is still a mechanism (stress overburdening existent resources), though in his view symptoms were not able to discern discrete disorders.
In contrast with the other manuals, Benjamin (2003:7) embraces medicine, explaining that “[t]he ‘problem’ of comorbidity disappears once you have viable theory to explain the symptoms.” What seems to be the case is that some version of the MM is rejected. The core of the MM, as I see it (following Benjamin 2003, esp. pg. 8), that an understanding of aetiology and course can lead us to specific treatments, is inherent in all the theoretical schools I have studied. We are left then with a paradox: the MM is rejected, but there is nevertheless a distinctly medical approach to treatment. Why is this?

Of all the possibilities, self-interest is the most plausible to me. Science legitimates psychotherapy. But, on the other hand, psychotherapy is also a business, doubly so if one has written a treatment manual and/or other books on the subject. Rejecting this paternalistic iteration of the MM allows one to collude with the proto-patient against those domineering medicos, while simultaneously embracing the benefits of a scientific approach to psychopathology. It is, as so many sociologists would have it, a ‘political’ move. This strategy enables therapists (or at least those in my respondent pool) to play both sides in an artful con. Such analogies are misleading – there is no deception, as these individuals believe what they are saying. It is paradoxical only because they are rejecting a folk rendition of the ‘MM,’ which is the one to which sociologists seem to have clung. Once one is able to take the psychotherapist’s role, there is no problem. ‘Medicalisation’ is, in my sense at least, not an unmitigated evil: done correctly, this approach to psychopathology offers real succour for real suffering, and acknowledges the patient as an agent in this process.
(IV) Discussion: The Minimal Medical Model

In determining a way to treat pathological narcissism (or any other psychiatric disorder), it is necessary to formulate a theory of its origins. This aetiological hypothesis enables the clinician to predict what sorts of situations will be problematic for the patient, and serves to target treatment. Theory leads the practitioner to attend to some details and not others, though this can always change as more information is revealed through the course of psychotherapy. Davies (2009) neatly summarises this: “Hesitancy, reservation, and the anxieties of vacillation are largely eliminated by the conviction that one’s model can render the mysterious fathomable, the perplexing discernible, the strange familiar and routine” (182).

While each lineage (e.g. COP, TFP) develops a local stock of wisdom on dealing with various stages in the course of treatment and the illness’ aetiology, these schools are much like psychiatric disorders – they often share many factors and aren’t cleanly separable. Amalgamation, segregation, and translation are the three primary modes whereby the traditions served to interact. Conceptualisation’s strength shows in that the Kernberg-Kohut controversy appears to have largely been settled in practice, but remains a point of contention for some.

I have also suggested that despite sometimes fierce opposition between schools (largely, but not exclusively at the psychodynamic-behavioural cleft), many interventions in the psychotherapy of NPD can be thought of as building the patient’s capacity to tolerate difference, imperfection, shame, and conflict. There is also a broad agreement that there must be “emotional vibrancy (Lebensqualität)” (DE-P-9,
in therapy – but this common factor appears to be overlooked due to the divergent methods used to obtain it. Models help to guide treatment independent of aetiological concerns in that they provide what I have facetiously formulated as psychotherapy slogans. An example of this from outside ST can be found in a TFP clinician’s summary of why he believes personality change is possible:

“Now how you get [personality change], you’d have to read our manual but you know it’s through immersing yourself in a shared experience where the affect is palpable and then you get the person to observe it with you. You just engage their reflection in their interpersonal emotional experience. That’s just a nutshell.” (US-P-1. 28.05.2014)

If one uses such a motto (“What would a healthy parent do?” or “You just engage their reflection in their interpersonal experience”), one can attend to more details of the interaction. They allow psychotherapy to become more intuitive, more habitual, thus freeing cognitive capacity for situational analysis.

Shame and blame are large components of psychotherapy with a narcissistic patient. Some practitioners thus use masking mechanisms to misattribute or camouflage culpability, or to enable a narcissist to claim credit not entirely their own. In general, modelling that one can survive as a “flawed object” (to use the psychoanalytic jargon) is a universal method, but can be accomplished in myriad ways. All therapies also developed means of distancing the patient from their symptoms, which appears to be central in the treatment of most PDs. Most if not all socialise the patient into a shared system of thought, whereby the patient can use the technical language they are given to render the familiar foreign. This shared jargon serves both to give the patient an avenue for metathought, and to build solidarity between patient and practitioner. “Frames” or “treatment contracts” are often used to inform
patients of their role obligations, and to inform them of the psychotherapist’s own.

Two broad aims (“confronting grandiosity and teaching empathy,” CA-P-1, 21.08.2013) for the treatment of narcissists were identified by my informants. There exist different, but ultimately compatible, means of reaching these ends. What is suggested by these practical commonalities is the existence of something concrete that all interventions operate on. The discrepancies arise in abstractions: the models used by each school. My informants and the therapy manuals suggest a complex relation which I’ve called the medical model morass. I propose that there exists a minimal medical model (MMM) underlying all these treatments. The MMM consists of:

1) a conviction that specific psychological dysfunctions are knowable and can be found using their school’s conceptual tools,

2) a belief in multiple (but specified) aetiologies which allow the therapist to match their interventions to these disorders, and

3) an understanding, usually rooted in clinical observation, of said disorder’s course, enabling the clinician to determine the patient’s prognosis.

Embracing the MMM while outwardly rejecting a paternalistic MM makes it possible for practitioners to have the benefits of scientific studies of psychopathology and simultaneously collude with the patient. We have established the relationship between the theoretical schools and the MM, and examined how this structures the patient-practitioner interaction. With the dreaded dictator medicalisation deposed, what frays await our conceptual chieftains? And how will this war impact their subjects, the clinicians and the clients?
Chapter 7: Interventions and Interactions: Managing Psychotherapy’s Many Boundaries

“But the literature I’ve looked at in talking to people who do therapy in all sorts of areas, a lot of it seems like it works if you can get people in it and they want to change and stick with it. It’s all case study or small subsets, there’s some with a little bigger samples – usually looking at borderline and they have some dual diagnosis with NPD, but DBT seems to help, group therapy seems to help, [CBT] seems to help, [ST] seems to help. [There’s no therapy that doesn’t work.] They seem to work if they get people in them. Probably within those cases therapists are trying to address specific issues, albeit in a pretty cognitive way a lot of the time.”

(US-SPP-1, 26.05.2014)

A research psychologist I spoke to ultimately came to the above conclusions when asked how social and personality psychology could help improve the treatment of NPD. This quote begins after he has explained what he feels are the “ingredients” of narcissism, and thus what he feels are the appropriate types of intervention for this psychopathology. He raises, however, in a relatively brief time, three key areas of difference that psychotherapists must negotiate: (I) between patient and practitioner, (II) across therapeutic traditions, and finally (III) across a heterogeneous patient pool. Other correspondents clarified two further concerns, (IV) cross-national differences and (V) treatment indications. Each of these topics will be considered in turn.

To some extent, then, this chapter will address the concerns of the earlier chapters
from another overlook. The focus moves, roughly speaking, from the micro-concerns of the consulting room to more macro-perspectives, closing with the worldwide population of pathological narcissists. Two central themes emerge from the above excerpt: first, that there are a great many similarities across the different psychotherapies, and that these treatments have a common foe.

In Chapter 6, we saw some of the particular interventions used by psychotherapists to establish rapport, and in some cases to define the foundations of the relationship. Related but distinct is the question of interpersonal or social distance. While a treatment frame or contract provides one means of doing so, there are many more immediate means of negotiating this social tie. The similarities and differences we see there take us into practitioner’s self-perceptions and management of theoretical boundaries. Cross-national differences tend to be more in how narcissism presents, leading us back into treatment indications for various patients with NPD. To some extent we return here to the world of diagnostic-distinction, as there is a shuttling back and forth between intrapersonal and interpersonal variation. How does theory provide resources for clinicians to manage these differences? We enter at the interactional level, face-to-face in the consulting room.

(I) Patient-psychotherapist relations: “[A]lliance building is through seeing the patient’s potential…”

The ‘talking cure’ is more reliant than most Western clinical techniques on a positive social tie between practitioner and patient. Psychotherapy manuals and my informants alike therefore accentuate “alliance building” and how this relationship
ought to be managed. A certain amount of distance must be kept between the
interlocutors (cf. Luhrmann 2000:102-103). How much distance, and how it is
maintained or relaxed, varies across theoretical traditions.

Let us launch with two therapeutic stances, where it is uncertain whether conceptual
or professional differences which dictate the difference. A social worker describes
his therapeutic work with narcissists as relatively undemanding:

“…[S]o they really don’t want much. They make few demands of
the therapeutic relationship, so I offer them no more therapeutic
work than what they ask of me. For that reason, I don’t find it
terribly demanding, but there’s not much coming from the other
side, I have to say.”
(DE-PP-1, 11.03.2014)

In contrast, a Kleinian (DE-P-8, 6.05.2014) describes his efforts to shift “many
narcissistic patients” from a position of seeking only self-optimisation or wanting
nothing more than coaching or counselling: “We naturally question that, but if the
patient ultimately seeks support at this level in the first instance, we would provide
them something like that.”

What distinguishes these two approaches? Both work at least partially in hospital
settings, so the likely suspects are occupation or orientation. Other social workers I
spoke to (CA-CSW-1, US-LCSW-1, US-PP-2) were all more aggressive, with the
schema therapist (US-LCSW-1) being the most active in trying to build motivation to
change. By process of elimination, then, it must be either the model or individual
differences,

Countertransference (to oversimplify, what emotions the patient stirs up in the
therapist) remains central to any therapy relationship. As in everyday life, it can be a source of information. I asked a clinician (US-CP-1, 19.03.2015) about countertransference, and how it might be scientifically approached. For some reason, I went on to mention how the psychotherapist’s personality, psyche, or self can be seen as the tool used in psychotherapy. My ultimate question was whether this could be done, how, and if I was just ignorant of these attempts:

“But the idea of countertransference, in my view, is it’s not stuff that the therapist brings in that they should move out, get rid of, in order to fully and more clearly grasp the patient. My view is every therapist has a personality, and that if we work in a therapeutically immediate way, then we’re going to figure out how our personality is impacting our relationships.”

Psychotherapy is – and must be understood as – a social encounter between two people according to this informant. Much as some narcissists treat the therapist as an ATM (US-P-1) or “almost like a robot” (DE-CP-2, 8.01.2014), it is not a purely role relation. He went further still to suggest that in his opinion the healing came from this real bond between patient and provider:

“The vehicle of change, for me, is the relationship, not my self. So for me, it’s about how does whatever I bring into the room and whatever you bring into the room interact to create this moment, this relationship, this set of patterns. How similar or different is it from other patterns? If it’s similar, we can ask, ‘How does the patient understand that, that it’s happening here too?’ If it’s different, we can ask the patient how do they understand that it’s so different from here. And either way we’re going to be making therapeutic progress in the relationship.”

(US-CP-1, 19.03.2015)

I think it inane, but it must be said that emotion suffuses every interaction. While some clinicians are hesitant to lay much evidentiary weight on these ‘soft signs’, they nevertheless form part of the therapeutic encounter.
Interestingly, a psychoanalyst pointed out that the therapeutic relationship can be a positive contingency for a narcissistic patient. When asked why a patient had cited a “good connection” as the reason why he wanted to pursue telephonic therapy, the informant opined:

“…[I]t's a novel thing to have someone who's able to talk with them at an intimate level and have enough skill to form a relationship with somebody who generally doesn't form intimate relationships. So it's a pretty big high to feel like somebody gets them. And it's intriguing to them, and it's sort of tempting, they kind of know that they're missing out on relationships with people.” (US-PP-1, 23.05.2013)

As clinicians might expect, the relationship isn’t rewarding in the same way as it is to borderline patients, but nevertheless the social tie needs to be factored into treatment. The practitioner presented this as a case he’d sought consultation on, but that it came too late.

“…what they did talk about when I did was the need to have him come in and be face-to-face or in the office on a regular basis just to re-establish both the frame and also kind of diminish some of the more extreme kinds of projections that tend to happen when you don't see someone face-to-face.” (US-PP-1, 23.05.2013)

While he couches this in Freudian terms, there is little difference here between unmanualised psychoanalytic treatment and its distant cousin, DBT. Linehan (1993a), coming from a behavioural standpoint, doesn’t reference projection when advising against ‘falling into the trap’ of conducting individual psychotherapy over the phone during calls. TFP is perhaps the most explicit about attending to the patient’s nonverbal communication (Yeomans et al. 2015:155), but this data is implicitly valued in all traditions I encountered.

Further evidence of the similarities across schools can be found in our French-trained
psychoanalyst’s exhortations to bear in mind how the institution relates to the patient:

“… and here you must take care that the institution – that’s a relatively dominant construction (Gebilde) anyway – take care that narcissistic mechanisms don’t continually crop up. These are first of all irritating mechanisms, where you must then lock people up, and so on. How does such a sign, [such] developments move, how do you get it under control (in Griff) early enough, how do you notice it so early so that you don’t allow it to come to an ultimate crisis (bis ins letzte zuspitzen lassen).” (DE-P-7, 13.02.2014)

It must be noted that this was discussed in the context of forensic work. But even here with a firmly analytic individual, we see not homo psychologicus but rather man as an interpersonal being.

Both a North American analyst (US-CP-5, 15.05.2014) and a more holistic – albeit from the CBT side – German clinician suggested the centrality of the therapeutic alliance. The German psychiatrist (DE-P-1, 11.02.2014) used the COP metaphor of a relationship bank account (Beziehungskonto) from which one can later “make withdrawals at certain points and convey your opinion somewhat to someone, naturally with the risk that they’ll react to it irritably or aggressively.” He went on to explain that there are different case trajectories (Fallstrecke), one being:

“…[T]hat [the patient] has reached a certain point, and is sort of stuck at that spot. So they don’t progress any further and that they’ve discussed the conflicts but they in principle haven’t sort of discovered the underlying narcissistic schemas. Another route is that patients know (kennen) and understand (wissen) and admit all their narcissistic schemas, but they can’t change. That’s the point where you have to, how should I say, take a somewhat measured approach.” (DE-P-1, 11.02.2014)

While the North American doesn’t use the banking metaphor, the same approach is undertaken with at least some of her narcissistic patients:

“Sometimes alliance building will take several months. First of all, to identify a problem that the patient sees as a problem and is
willing and motivated to work on can take quite a long time for some patients. That may also not be the major problem in their lives, but it’s a door-opener, something to start with.” (US-CP-5, 15.05.2014)

Central in both narratives is winning the patient’s trust, but there are two paths for this purpose. The more psychoanalytic practitioner takes a foot-in-the-door approach, whereby a point of entry problem (which both therapist and patient can agree upon) is used. In contrast, the more cognitive clinician begins with convincing the patient that they will be respected and even liked in the consulting room. Both practitioners seek solidarity with the patient, but the psychoanalyst does so by finding a common ‘enemy’, whereas the other uses a variant of everyday techniques.

Aggression and destructivity came up in two interviews. It came up in conversation with a Gestalt therapist (DE-CP-2, 8.01.2014) when I asked how she balanced the need for warmth and control: “So one can naturally say it very, very simply: (she smacks one hand against the other) Warmth for the people, and boundaries for the destructivity.” One TFP practitioner (US-P-1) frequently referenced aggression, but spontaneously spoke of it whilst explaining alliance building. He stressed that TFP was distinct in the way it dealt with the patient’s hostility:

“But where we find that the alliance building is different in TFP is we welcome in all the negative transference, all that devaluing, any hostility or aggression. We make the patient know that they’re welcome from A to Z, every different aspect of them is welcome, and that we can know them in their total entirety, including what might be difficult to experience as well as what might be easy to experience.” (28.05.2014)

I argue that TFP’s difference is shown more in their approach to alliance building. Other therapies, particularly COP, offer the patient a warm reception or even accept
the patient’s self-praise as a way of banking ‘relationship credit.’ The justification for their coolness relative to other schools can be found in their conceptualisation of social dynamics:

“We are concerned that if you’re too active in this kind of positive alliance building at the beginning, then the patient might think, ‘Oh, I’m not supposed to bring in my anger and frustration here, he’s presenting himself as my buddy so I’ll sort of’ – I mean this is unconscious – ‘keep that outside of the session.’”

(US-P-1. 28.05.2014)

While my respondent speaks about an unconscious process, we can understand this in terms of learning. The rules of therapy are different from the rules of acquaintanceship. This conceptualisation shows the patient as seeking a model or prototype by which to understand this new social tie. Role induction is therefore vital, as it teaches the patient the ‘etiquette’ governing the definition of this particular relationship.

TFP then establishes a mode of interacting, not where the therapist is ‘neutral’ in the sense of being stony faced, but whereby they subtly convey solidarity with the patient or what the patient could become. These rules curtail the expression of praise:

“First off, we think that the alliance building is through seeing the patient’s potential, and speaking to that. So for instance, when we set up the contract, we’re doing this because we believe the patient can really grow in autonomy, in independence, in better functioning, and in better satisfaction. So we feel the patient can get that we think they have more potential, and in discussing the contract, we might say that, say, ‘You know these are ambitious goals because I think you have potential that hasn’t been fulfilled and I want to work with you toward that, if you’re interested.’ Some people say, ‘No, I just want a chronic maintenance treatment.’ So if somebody does something good, we can say that sounds good, like when the woman said ‘I got the job’ and I said, ‘That’s good.’ So I mean, to me, that’s validation enough. To heap
By setting such sentimental boundaries, the therapist distinguishes between the consulting room and the outside world. Difference is emphasised in an aspect of the relationship that is very much the same across the treatments considered.

What TFP therapists refer to as “technical neutrality” (Yeomans et al. 2015:167-174) seems to describe much the same behaviour as does “radical acceptance” in DBT (Linehan 1993a:515-517). COP’s early “complementary relationship construction” appears at first blush to be quite distinct from the other formal approaches. A similarity to other cognitive approaches can be teased out, however. DBT advises the clinician to find the “kernel of truth” (Linehan 1993a:241-242) in what the patient is saying, feeling, or doing. The complementarity in this stage of COP is that the patient is praised not for anything at all, but for things which are actually good. A shared ground is found, or as Linehan might say, both patient and therapist have located the gold in the sand. COP and DBT (see esp. Linehan 1993a:242-249) are more conventionally ‘friendly’, but the negative aspects (boasting, hostility, etc.) are never reacted to as they would be in the real world. Symptoms are tolerated or ‘contained’ – which is precisely what TFP advocates.

All these approaches give the practitioner a model for maintaining dramaturgical discipline (Goffman 1973:216-218). In plain English, these diverse mechanisms allow the therapist distance and detachment from the mundane world in a certain

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39 Yeomans and colleagues (2015:167) define technical neutrality as “maintaining a position that does not ally with any one of the forces involved in internal psychological conflict… [It] is a position of equidistance from these competing forces that fosters understanding and observation of them – a process the patient is invited to join in.”
way. The shared nature of this tool (whichever it may be) makes the performer a member of a community, which encourages commitment to the role. Having pre-set formulas and patterns of action leaves the psychotherapist better able to adapt to any personal slip-ups or unexpected turns.

Touch is another arena where psychotherapy is distinct from a ‘real’ relationship. In intimate relationships, physical contact occasionally occurs, depending on the type of tie and the circumstances. A conceptual cleft emerges here in the corporeal question. While Linehan (1993a:386-388) enumerates eight rules on “warm engagement and touch in psychotherapy,” only half distinguish it from TFP: “Physical touch should express an existing therapeutic relationship”, “be sensitive to the patient’s wishes and comfort”, “be within a therapist’s own personal limits”, and finally “be potentially public.” Potentially public “means simply that the therapist should not try to keep the fact of hugging a patient good-bye, for example, a secret” (388). Linehan (ibid) further recommends that the therapist “periodically [discuss the topic] at supervision/consultation meetings,” and “not move out of the camera range when hugging a patient” should they film sessions. TFP is broadly prohibitive of physical contact between patient and practitioner, as we might expect of a psychodynamic psychotherapy. Both TFP and DBT agree, however, that “sexual touch is never acceptable” and “[w]hen inappropriate touch or a sexual overture is initiated by the patient, the therapist should ‘talk it to death’” (Linehan 1993a:388; compare Yeomans et al. 2015:314-319).

Treatment termination is done gradually in CBT-family therapies by tapering off the
number of sessions. Both TFP and the CBT-family approaches I have studied leave open the possibility of booster (or consultation) sessions, or of later resuming the therapy (e.g. Yeomans et al. 2015:363, and CH-P-1, 22.01.2014; Linehan 1993a:457-460). There is a difference in that in “the patient moves from the category of patient to that of ex-patient, and the therapist goes from the role of therapist to that of ex-therapist” (Linehan 1993a:457). Linehan (ibid) continues, reminding us that in “‘ex’ roles… the fact of a once intense and intense positive attachment is recognised and valued.” This transition is negotiated between patient and provider (460). DBT is thus perhaps the most ritualistic about its endings. As elsewhere, broad similarities exist: TFP uses separations to model termination (Yeomans et al. 2015:356, 361-2), which seems to me just another way of “periodically” “touch[ing] on” (Beck et al. 1979:317) the subject. The strongest proof of path dependency is that both CBT and its descendants (Beck et al. 1979:318-319; Linehan 1993a:459; Sachse 2013:74-75) endorse the psychoanalytic assumption that “mental health is not a dichotomy but rather a continuum, with many points along that continuum” (Beck et al. 1979:319).

Some variation exists across lineages as to the relationship’s role. There seem, at least in the case of pathological narcissism, to be three ways of approaching this social bond:

1) one sees it as foundational, a basis from which to work,
2) it is a vehicle for the therapy,
3) it is the therapy.
An example of the bond as bedrock conceptualisation came in the context of a German psychoanalyst’s (DE-CP-5, 4.03.2014) discussion of the relationship between clinical experience and “the psychiatric, psychoanalytic, [and] psychological sciences.” He explained his understanding in terms of theory, and distinguished between “a theory in systems of technical expertise” and that used in describing people and their interactions. This distinction reflects Hacking’s (2001) distinction between interactive and indifferent kinds (cf. Rose 1999:9-10 on these looping effects). Due to this difference, he argues that “we misunderstand when we think we can apply a theory”:

“But now when I deal with people, I can never apply a theory in the fullest sense of the word, because the other person I’m dealing with could always react completely differently, therefore the theory can’t fully hold. And that means, every professional practitioner in psychotherapy is someone who has the theory as a resource in their cognitive environment. But they don’t apply the theory, rather the theory shaped him – His knowledge, his competence, his strengths. But how they then, so to speak, convey it to the patient, is from the theory only to a small degree, so to speak. Rather more influential is the interplay (Zusammenspielen) between the patient and themselves. And that’s a totally different aspect.” (DE-CP-5)

He then goes on to give the parable of a mathematics lesson, and how a teacher varies their presentation according to students’ needs. The teacher brings “a human touch (lebendiger Kontakt)” to the encounter, which “means the teacher has to be bonded to their students.” The psychotherapist, he argues, is similar: “The therapist has to be bonded to their patient, and the magic happens (das wesentliche spielt sich ab) in that bondedness” (DE-CP-5, 4.03.2014). A Gestalt therapist (DE-CP-2, 8.01.2014) also stated a conviction that the relationship was the basis for therapy, but didn’t give such an elaborate account.
I immediately followed up with this clinician (DE-CP-5, 4.03.2014), asking whether treatment is primarily a form of relationship. He explains the particularities of psychotherapeutic exchange, namely the allowance of metacommunication. For him, it is this peculiarity which leads to “new meanings”:

“Yes, but not primarily, the relationship is the base of treatment, and the art is to, how should I say, establish a ‘two-level conversation.’ On the one hand you talk with each other, on the other you establish a level where what’s being spoken can constantly be analysed. And thereby in the interchange between the levels ‘new meanings emerge’ constantly, new meanings just emerge and they’re sometimes unconscious meanings from the patient’s unconscious, sometimes they just emerge simply from the interaction itself.” (DE-CP-5, 4.03.2014)

By virtue of this communicative quirk, the patient is enabled to distance themselves from the symptoms simply through the peculiar speech patterns of the consulting room. The talking cure thus requires some sort of ritual separation from the mundane world, much as the latter may be a topic within therapy. Metatalk (talk about talk) serves to provide this ritual separation, just as metathought enables the patient to gain distance from their symptoms.

Other therapy traditions see more of a hybrid role for the relationship: “The relationship in DBT has a dual role. The relationship is the vehicle through which the therapist can effect the therapy; it is also the therapy” (Linehan 1993a:514). I saw a similar understanding expressed earlier by a clinician using TFP but also interested in interpersonal theory (US-CP-1, 19.03.2015).

The phrase “corrective emotional experience” came up in an interchange with a relational-psychodynamic clinician, which led me to ask him to unpack how he uses
the relationship and how he builds this particular experience. He explains that empathy plays a central role, and that this can take the form of interpretations, but it more often than not is less explicit:

“Often folks who have serious narcissistic problems have had some kind of deficits in their relationships with significant figures, such as they haven't been properly empathised with. So the experience of having empathy, not only being empathised with, but having that empathy, that empathic understanding of the patient guide how you treat the person, how you respond to them. I think that makes a difference. I think gradually, over time, that helps the patient see that you're not going to treat them the way their original object did, that it's not necessary to utilise the same kinds of narcissistic defences and mechanisms that they've had to rely upon, or that they feel they've had to rely upon, because you're not a threat to them. They may enter therapy feeling that you're going to damage them somehow, or you're going to exploit them somehow, that they have to keep their guard up. And over time, simply through the way you relate to them, you show them what's going to happen. You don't necessarily need to point that out to a person. They'll see that.”

(CA-CSW-1, 6.09.2013)

In terms of technique, this approach could be seen as behavioural (though cast in psychoanalytic terms) as it stresses removing the conditions which trigger narcissistic responses. Patients are, it might be said, gradually conditioned to expect empathic responses, if only in therapy.

The feeling becomes stronger still as the informant begins to discuss control-mastery theory, which the respondent argues “is highly consistent with object-relations theory”. What the theory proposes is “that these pathogenic beliefs are at the heart of psychopathology,” leading him to draw a comparison between the academic and the patient. Both test their beliefs:

“…[S]o a narcissistic patient may grumble at you and criticise you and try to put you down, to test how you'll respond to that. Now depending on the particular person and what their original object-relations were like, that led them to feel that they need to do that,
you have to have a particular response to that kind of test that's going to help the patient disconfirm the pathogenic beliefs that lie beneath that behaviour. So if you become upset and your feathers get all ruffled when the patient criticises you, the patient may actually feel that there's no room for them to voice their negative opinion, and so it may actually confirm a pathogenic belief that they have. They may be unconsciously hoping that the therapist will accept the criticism, listen to it, not be ruffled by it, but eventually maybe come to understand what it means to the patient. And that in itself may have corrective properties for that person. Of course, this usually has to happen time and time again, and in a variety of ways in order for change to actually occur.”

(CA-CSW-1, 6.09.2013)

Two things are striking here: the overlap between control-mastery theory and CBT-based approaches to narcissism, and how theory is used to guide treatment. We see, as in COP, a prediction of certain behavioural tests the therapist must withstand in order to prove themselves to the patient and not confirm their “pathogenic beliefs” (e.g. Sachse 2013:19 for tests as a central characteristic of PDs). Perhaps owing to Kohut, both ST and psychoanalytic psychotherapy – as portrayed in control-mastery theory – have an element of “limited reparenting”, which is more pronounced in ST.

The correspondence between CBT proper and various psychodynamic approaches was suggested by another informant (US-CP-3, 2.08.2013), but is here made manifest. In describing the compatibility of object-relations and control-mastery theories, “an internal object-relation can be thought of as a schema or a set of beliefs about the self and important others, and of course there are affects associated with that” (CA-CSW-1, 6.09.2013).

Models allow the clinician to see a stimulus in a way unlike an ordinary observer, and it allows them to make predictions. I take this report as an example of a clinician’s being ‘shaped’ by their theoretical stance. More counterintuitive is that
the highly anti-analytic COP and a relational psychoanalyst come to the same understanding from different premises. These specific “tests,” and the clinicians' comprehensions of them as such, indicate there is some common object here – if only what we can vaguely lump as “PD.” In further focusing on how clinicians perceive the differences between therapeutic schools, we can further untangle rhetoric and routine clinical activity.

(II) Psychotherapies at the border, or: “But I can only answer from within my own model.”

In discussing how he would respond to CBT criticisms that clinicians can’t change personality, a TFP clinician (US-P-1, 28.05.2014) prefaced his answer with the above remark. Practitioner-practitioner translation, a phenomenon encountered in diagnosis and economics (Fourcade 2009:92), clued us in that my respondents were well aware of the boundaries between the different psychotherapies. A possible shortcoming of my data here is that I tended to explicitly ask about these distinctions in the German-speaking setting. However, some North American informants volunteered such statements, or were later probed about this link. Informant descriptions of distinctions between psychotherapeutic approaches ranged from quite tame appreciations of similarity to more fiercely-worded statements of difference.

In some cases, one of the differences pointed towards was that the same intervention was delivered on a different schedule. A COP practitioner (DE-CP-6, 25.02.2014) answered a question about homework, a distinctive feature of the various CBT offshoots, thusly: “We do that late in therapy, not at the beginning, as opposed to the
classical CBT therapists.”

A more drastic example can be found in a manual for *Interpersonal Diagnosis and Treatment of [PDs]*, wherein Benjamin (2003:110) offers the following advice:

“The reconstructive learning therapist draws from a wide range of available therapies. Techniques of psychoanalysis, experiential therapy, family therapy, group therapy, drama therapy, educational therapy, behavior therapy, gestalt therapy, and others are appropriate. Anything that leads to one of the five correct categories (enhances collaboration, facilitates learning about patterns, mobilizes the will, blocks maladaptive patterns, and/or teaches new patterns) is legitimate.”

Benjamin – and interpersonal therapy in general – seems more concerned with orthopraxy rather than orthodoxy.

The previously-cited COP psychotherapist was queried about the differences between CBT (“in the narrow sense, Beck, Freeman, and so on”), ST, and COP. His response gives us insight into the conceptual and methodological classifications used by my informants to split one psychotherapy from another. We begin with a theoretical distinction which marks the perceived split between classical CBT and COP:

“We also assume that there are schemas, that you have to clarify schemas, but we go over and above Beck and Freeman in that we say clients have not only characteristic schemas, but also manipulative [Spielstrukturen]. Yeah? So they manipulate and essentially try to draw in others. And that aspect isn’t brought up in Beck and Freeman.” (DE-CP-6, 25.02.2014)

There is an awareness of path dependency, or of a shared heritage, in that the respondent then goes on to say, “But with respect to schemas…we’re practically identical (deckungsgleich).” On Sachse’s (2013) *Spielebene*, “the person already pursues interactional goals that don’t reflect their ‘real’ motives, rather … avoidance-
goals: the norms and rules usually don’t reflect what the person ‘actually’ wants and what would actually put them at ease.“ (23). What transpires, Sachse (ibid:38) argues, is the continual frustration of the person’s basic motives, because the individual’s manipulative behaviour insures that their dominant motive isn’t satisfied, and thus blocks them from pursuing other motives.

Then there is a class which argues methodological superiority, usually on the basis of doing something more “thoroughly”:

“And from Young, from [ST], we distinguish ourselves in that we generally do a far more thorough schema evaluation, a much longer, far thorougher schema clarification process, and a far more thorough treatment of the schemas. Yeah? But we don’t have something like what Young calls ‘reparenting’ and we also don’t differentiate [schema] modes. So in places we may partially overlap, but [we’re] partially something fundamentally different from [ST]. But there are some areas of overlap, so you’d say there are similarities between the systems.” (DE-CP-6, 25.02.2014)

We see here a hybrid of methodological superiority, technical difference (i.e. without explicit valuation), and theoretical distinctions. A purer example of supremacy can be found in a psychodynamic psychiatrist’s (CH-P-1, 22.01.2014) response to a request for his thoughts on the idea that pathological narcissism could be relatively quickly treated with CBT or DBT: “On that front I’m pretty sceptical. So you can certainly achieve something there, but no deep-seated change (tiefgreifende Veränderung).”

Sometimes the differences were seen as more semantic than substantial. A German CBT clinician (DE-CP-3, 22.01.2014), in training when interviewed, compared CBT, COP, and ST by explaining “that [COP] and [ST] are aspects of CBT.” She stated
that CBT “mainly intervene[s] on the behavioural level” and, in contrast, COP
“look[s] deeply, what’s the cause for this behaviour shown by the patient.” Her most
interesting comments regarded the distinction between ST and COP:

“And [ST], it [looks at causes] too, it works with this – I can’t
reproduce it so exactly because I’m not well-versed in it – mode
and these individual mode-concepts. I believe it’s just another
language that [ST] uses there.” (DE-CP-3, 22.01.2014)

We see here some confirmation of the genealogical or path dependency effect by an
informant, which was also present to an extent in the previous quote. I don’t wish to
overstress this quote, as the respondent herself emphasises a lack of special
familiarity with ST.

Purely semantic separations were also sometimes acknowledged in passing. In
describing schema modes, a clinician gave a telling aside:

“And so when they’re triggered after certain conditions to
experience those, they flip into coping modes. Some would call
them defence mechanisms in other models. So they flip into these
coping modes to try to avoid, you know to survive, the threat to
their ego or their emotional survival, but the modes are maladaptive
for the most part.” (US-LCSW-1, 16.09.2013)

I interpret this as an instance of conceptualisation obscuring similarities in the
understanding of certain basic phenomena (here maladaptive responses), and so
blocking therapy integration.

Others differentiated therapies based upon their purposes, targets, or results. Here
we return to the TFP clinician who introduced this section. His discussion of
personality structure reminded me of a CBT practitioner’s (DE-CP-7, 21.02.2014)
claim that changes in fundamental personality were illusory (paraphrase). I asked
him how he dealt with that criticism when he faced it:

“Well, it’s a very common criticism. First of all, it depends on how the person’s defining personality. (CFD says right and laughs) I don’t know exactly how a CBT person defines personality. But I have to say, see I’m not into CBT so much, but I don’t know if they have a model of the mind as much as a psychodynamic approach, so without the model of the mind I guess they’d be talking about changes in fundamental personality traits, I guess. But I can only answer from within my own model. If we find that personality, as we would argue, is based on the internalisation of kind of paradigmatic relationships and images of self and other, that those can evolve with your help, from being fragmented and extreme to being integrated and much more modulated.”

A clinical example then contrasted a patient’s portrayals of a parent early and late in treatment. My informant summarised this example as follows:

“To me these huge changes in sense of self and other I call personality change, because along with that she’s much more able to modulate her affect, she’s much more able to enter into relations with others, she’s able to have friends, she got married, so I think you have personality [change].” (US-P-1. 28.05.2014)

Some might point to the circular nature of this – we can affect personality change, by our definition of personality. Given the backdrop of all my other interviews, however, I propose that what we see here is differences in what therapies target, rather than a fundamental disagreement as to the psychiatric disorders they are treating. The above quote can be contextualised by another from a young clinician who utilised either TFP or a “general interpersonal approach” in his work with narcissists:

“Unlike DBT, TFP tends to be much more flexible with regard to applying it to patients that don't present as the typical DSM borderline. So patients whose self-destructive tendencies don't manifest themselves explicitly in cutting or overt suicidal gestures or attempts, TFP tends to be a lot more amenable to working with patients who aren't doing things exactly like that.” (US-CP-2, 10.05.2013)

This line of argument can be further supported by the TFP manual’s suggestion
Yeomans et al. (2015:146): “It is increasingly common that patients who have benefitted symptomatically from more cognitive-behavioural treatments such as DBT then seek TFP to address identity and interpersonal and engagement-in-life issues in more depth. This sequence of treatment has often proved beneficial.”

Since all the evidence heretofore has come from sources associated directly with TFP, one could argue that I have not escaped the tautological problem sociologists so smugly serve up. We see however the implication that different treatments have varied functions below.

“There are very useful techniques, the Buddhist thing [in DBT]. So I'll use those after the person has come to terms with the need to give up, in the case of narcissism, being centre of the universe and the terror, the despair, the grief of that requires a reprogramming of the primitive brain, the affect regulators. And DBT’s fabulous for that. Before that, the narcissist just isn’t interested.” (US-CP-8, 20.08.2013)

Earlier in this same quotation, the respondent indicated her disagreements with psychoanalysis and some of the “just raw empiricism of some of the versions of behaviourism.” We aren’t dealing with a sleeper cell, but rather we find some independent confirmation of the different targets hypothesis.

One informant (US-CP-4, 3.05.2013) thought that “theoretical orientation is really overblown,” stressing that his focus was more on their being “a solid clinician.” He defined this as their being “good and thoughtful and evidence-based,” and having “their motives are in the right place, in terms of trying to help patients.” The same was true of “training background,” leading him to conclude:

“If they provide something useful, in fact, a lot of times I get a lot more out of somebody who doesn't think like me, because they'll
raise issues I hadn't really thought of. So generally speaking, I'd probably prefer someone who I thought was a really good clinician who tends not to think about things the same way I do.”

(US-CP-4, 3.05.2013)

This individual markedly references his own (perceived) idiosyncrasy. Equally important, however, are his references to science (“evidence-based”) and different forms of thinking.

This idea that conceptual differences generate diverse ways of seeing is further elucidated by a US psychiatrist regarding differential diagnosis:

“Interestingly, it’s often confused and an issue has been an overlap between bipolar because bipolar patients have been hospitalised for years, being called narcissistic. But I would say the fact that these people were mistreated, because they were just labelled narcissistic when in fact they were bipolar. Now that doesn’t necessarily mean that all narcissistic patients are really bipolar, that’s just an example of how different perspectives a lot of times don’t appreciate the whole picture. Definitely a lot of bipolars can appear narcissistic. This relates to the biological link between them, but not all narcissistic people are really bipolar.”

(US-P-2, 11.07.2014)

This practitioner espouses the ‘how you see determines what you see’ model advanced here. Essentially he says that overly-rigid adherence to thought styles can lead to mistreatment. Caution is the keyword, and he implies that the mistake can just as easily be made in the other direction. Both he and the interpersonal clinician cited above indicate that different understandings might not be as incompatible as they are sometimes taken to be.

Far and away the largest category of quotes related to the assorted psychotherapeutic tacks taken by my informants dealt with methodological or conceptual distinctions. One of the strongest statements of difference was the distinction made between a
strictly Kleinian approach to NPD, and the Kernbergian/TFP method:

“For example, we never make therapy contracts with the patient, because we think that contracts, controls, and sanctions don’t really help the patient, instead they actually serve to protect the individual therapist but only make relating more difficult. In contrast with Kernberg, I think that you have to tolerate a lot of your own insecurity and uncertainty, and orient yourself by your own countertransference. So I don’t automatically know which intervention is right for which patient, rather it’s about reflecting on your own feelings and tolerating insecurity also. With Kernberg I get the feeling that it becomes clear too quickly what the therapist has to do, or that the therapist knows what’s good for the patient too quickly. But beyond that there are many similarities with Kernberg, primarily working in the here-and-now, orienting yourself towards the therapeutic relationship in the transference, working through the negative transference, those would be similarities. But no contracts, no sanctions (he laughs), no omniscience (*Allwissenheit*).”

We see the inseparability of knowledge and practice again. Models can be seen as directing how the therapist ought to relate to the patient: for the strict Kleinian, more formal contracting distorts the therapeutic alliance (“only mak[e] relating more difficult”) and intervention depends less upon predicting the patient’s next interactional (and thus psychological) move. Both are in the moment, but TFP leans towards a more medical style with its interventions based upon predicted course.

Further indicative is one practitioner’s citing case conceptualisation as a major point of difference:

“You can be a very good technician in the treatment room, you can be very good at implementing cognitive strategies, behavioural strategies, Gestalt strategies, interpersonal strategies, you can be very warm and compassionate and empathic as a therapist – which of course is essential, and all of these are *essential* to our model, but what makes it different, I think, is that it’s so informed by this somewhat complex but very, very important and robust conceptualisation of each patient. So I think that’s the part that most therapists become very passionate about even though it’s difficult and it’s tricky and tempting to rush to conclusions, but we
Personal attributes and technical competence are distinct, and don’t serve to distinguish ST. It is the way that the therapist understands the patient that makes ST stand out from its competitors: the intellectual technology is what is unique. This thought then directly leads the informant to contemplate on how the therapy relationship differs from that in other approaches. Note that she stresses not only the contrast, but also science in this continuation:

“We spend a lot of time using the therapy relationship, because a schema therapist is not someone who shows up in a therapist mode. We show up like a real person who happens to be an expert, and so I think that also differentiates us to some degree because we are more active, we’re more open, we are more self-disclosing when it’s relevant to the treatment goals, and we are basically formed in this model of reparenting; in a limited way trying to meet the needs of the patient. So I think it’s this really lovely blend of so many different evidence-based schools of thinking, but really ties it together in a very powerful conceptualisation.”

If, however, we are aware of ST’s history, this apparent uniqueness mostly falls away. Beck and colleagues (1979:6-7) emphasise “collaborative empiricism” in the CBT manual for depression. Features of this are also to be found in DBT (e.g. my informant [US-CP-10, 15.08.2013] being on a first name basis with clients), and in COP (see the previous chapter). Additionally, DBT and COP both have taken elements from other therapies (notably sharing emotion-focused therapy as an influence). Individual practitioners appear to amalgamate as a rule, rather than as the exception. What we are left with as unique is the model, the intellectual technology with its guiding principle of limited reparenting.

One informant explicitly pointed towards self-interest as a motivating factor in the
invention of ST. I asked him, “What differentiates CBT from other therapies?” and made special reference to ST. He gave a deep sigh, then replied:

“Well, Jeff Young invented [ST], but Jeff Young didn't invent the concept of schema. Beck talks about schema, I had written about schema long before Jeff published his work. Jeff talks about early maladaptive schema. I don't think schema in and of themself [sic] are maladaptive. What is maladaptive is our interpretation of them. So if I have a basic schema, a basic cognitive template, I'm stupid. That's not maladaptive, necessarily. If I say ‘I'm stupid,’ and then finish that sentence by saying, ‘and I'll never get any smarter,’ I surrender. I give up. But if the maladaptive idea is ‘I'm stupid, I will go to school and become less stupid.’ ... So the idea or schema ‘I'm stupid’ may even be motivational. So I don't buy Jeff Young's [ST]. I think he's cobbled together a little bit of John Bowlby's attachment theory, [a] little bit of CBT, I don't think it's terribly inventive. But people like to have their name on something. So he invented a theory and a model. I mean it's been tested empirically, but it's usually tested against a psychoanalytic therapy.”

(US-CP-3, 2.08.2013)

There is agreement between US-CP-3 and US-LCSW-1 on what sets ST apart, what differentiates them is their emphasis. Our more classic CBT clinician stresses the elements of self-interest behind this model (“people like to have their name on something”). The phrasing “blend” or “ties it together” (US-LCSW-1) versus “cobbled together” (US-CP-3) conveys a very different relation of ST to other therapies: either it is innovative integration or opportunism. It could be both, and thus thought of as Goffmanian (1973) “role enterprise”:

“[W]hereby a particular member attempts not so much to move into a higher position already established as to create a new position for [themselves], a position involving duties which suitably express attributes that are congenial to them.” (248)

Also striking in this excerpt is the speaker’s implication that this test is the wrong one. To infer still further, I would hazard that the unstated conclusion is that ST would not fare well against its psychotherapeutic parent.
In the subsequent exchange, however, the respondent underscored how some psychodynamic therapies are moving toward CBT:

“… What Kernberg has publicly said is, he conceptualises psychodynamically, and treats *often* cognitive-behaviourally. If you look at Michael Stone’s books, turn to the index, much of what he references is our book on cognitive therapy.[40] So I think at this point, there’s less of a distance between many psychodynamic writers, Kernberg, Stone, and others, and CBT. Someone like Masterson, there would be a much wider gap.” (US-CP-3, 2.08.2013)

One German psychiatrist offered the opinion that CBT has become more and more of a “unified psychotherapy” when asked about the difference between *Verhaltenstherapie* (literally behaviour therapy, but tends to refer to CBT [Stumm & Pritz 2000:352-353]) and *kognitive Verhaltenstherapie* (a literal translation of CBT):

“Really, in the development of *Verhaltenstherapie*, one has to say that there is no *Verhaltenstherapie* more in the sense the word would suggest, there’s also no longer a [CBT] in the sense the word suggests. That is to say in the meantime it’s becoming more and more of a unified psychotherapy (*Einheitspsychotherapie*) that has taken elements of Rogerian psychotherapy (*Gesprächspsychotherapie*) and *Tiefenpsychologie* (a general term for Adlerian, Freudian, and Jungian approaches, see Stumm & Pritz 2000:704-705) and also gestalt therapy, so that one has, in my opinion, to bid the word *Verhaltenstherapie* farewell, honestly.” (DE-P-1, 11.02.2014)

When I discussed this notion at the 2014 NASSPD conference dinner and preceding poster session with some of my colleagues, those who used CBT or DBT objected to it. The preservation of a distinct sphere seemed to matter more to these younger individuals than to a more experienced clinician.

In at least one case, clear statements of difference preceded what I interpreted as

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[40] I’ve been unable to verify this quote, despite repeated attempts.
‘admissions’ of similarity. A German practitioner closed an answer as to why ST did not more expressly deal with shame or rage with this description:

“That means the goal isn’t primarily to work through feelings, but rather to correctly categorise them. That would be what we in [ST] call ‘labelling’, that one finds the right labels (Etiketten). That’s something very hard for therapists with narcissists, to validate this [feeling] that you say, ‘I can understand, that in that one second it was hard for you, that you couldn’t do any different. You had to scream at her,’ although it’s shitty behaviour. (Both laugh.) So that’s the trouble, that one almost always (quasi immer) has try and keep all the parts in mind.’” (DE-PP-2, 3.02.2014)

He is here describing an earlier phase of therapy. There is here a parallel in the psychodynamic process of “making an economic interpretation” (US-CP-2, 10.05.2013) whereby “that's just sort of mapping it out, bringing it to awareness, bringing it into the discussion. And then from there you can go towards [a] deeper understanding [of] it, and finding more insight around it. Exploring it more.” We observe here an almost universal feature of the treatments used for pathological narcissism. It is not quite the difficulty he addresses, nor is it this watchfulness alone, but some combination of both. TFP does this by speaking of one dyad defending against another (Yeomans et al 2015:68-72) and accepting negative transference, whereas DBT references “radical acceptance.” I suspect some of my respondents would disagree, but it seems to me that these different names (e.g. in ST, remembering there is a vulnerable child and healthy adult mode which aren’t active whilst the current mode is) refer to the same relation to the patient. In interpersonal therapy, anything which does not “facilitate collaboration between the patient and therapist” or fall into one of four other categories of “correct intervention” is “probably an error” (Benjamin 2003:87-88). Other specifics of the patient-therapist relationship may vary, but on this front all therapies are united.
Similarities can be openly acknowledged or occupy a shadowy space, obscured by terminology. How do practitioners deal with the distinctions (real or imagined) between psychotherapeutic schools? One, and seemingly the most common, way of dealing with this difference is translation. Another is to simply wall one’s self off and deal only with people who share one’s understandings. An American (US-PP-1, 23.05.2013) included the following in his depiction of presenting a case to his psychoanalytic study group: “…if I'm presenting a case, these clinicians are sophisticated enough that I don't need to explain that this is a narcissistically disturbed patient.”

DBT has this encoded into the method itself, whereby the fourth modality of treatment is a weekly case consultation meeting with the other clinicians handling the case. While being a DBT clinician is not mandatory, an understanding of DBT principles (i.e. its intellectual technology) is. My only respondent utilising this psychotherapy prefaced her perception of the differences between her approach and other, non-CBT approaches:

“…I’ve never really been trained in psychodynamic treatments [and] so the information that I have is really just based on my own reading of journal articles and things like that. So just take everything I say with a grain of salt…” (US-CP-10, 15.08.2013)

Training can and often does leave a clinician with explicit knowledge of only one treatment. I suggest that this perpetuates the gulf between models, generating a need for translation. This problem is particularly pronounced in the Germanophone world, where training in psychotherapy is done through institutes after one has completed a relevant degree.
In addition to translation and segregation, there is a third means of dealing with the therapeutic divides: amalgamation. A brief introduction to blending can be found in this aside dealing with identity:

“And you know, by the way, sometimes I sound very psychoanalytic, and I guess I am somewhat, but I also do things like give them homework assignments. Right? So it's not necessarily just that stuff. And that is like an interpretation, sort of like a self-interpretation.” (US-CP-4, 3.05.2013)

In contrast with Davies’ orthodox analysts (2009:166-172), assigning homework may remain directive, but it isn’t seen as “sadistic.” Elements of both translation and amalgamation occur here: translation in that CBT methods are explained with psychodynamic intellectual technology, and amalgamation in that different interactional technologies swirl into one another to form a whole.

Sometimes other therapies just tumble in and out of the thread of conversation:

“What’s good in [ST] is working with this child-self (Kinderich) before I take away this person’s narcissism. That’s my experience that you have to let yourself be taken in by this game first. So Rainer Sachse [inventor of COP], complementary relationship construction. What’s very strong in [ST] though, is this ‘reparenting’.” (DE-PP-2, 3.02.2014)

I must add that this individual recommended the DBT manual as something one had to be familiar with in dealing with narcissists, and described his ST training as “overlaid” on his CBT knowledge. While this could simply have been narcissistic ‘name-dropping,’ I see this more as further evidence that practitioners tend to borrow useful elements from other psychotherapies for incorporation into their favoured method.
Earlier we saw how Kernberg and Kohut’s tactics for narcissists were combined in different ways by different therapists, despite being seen as opposed or even contradictory. One North American clinician (CA-CSW-1, 6.09.2013) did so through conceptualisation, through the intellectual technology of object-relations theory. He explained that he “tend[ed] to see more overlap and similarity” between the two approaches. Because he was less interpretative, he described himself as being closer to Kohut. These two points are then synthesised:

“Kohut's approach rests a little bit more on the idea, not that he exactly worded it this way, but of corrective emotional experience. So there's something about the relationship itself that has healing properties for the patient, [because usually patients] experienced some kind of trauma in their own object-relations. And although he didn't call his theory an object-relations theory, I believe that it is an object-relations theory, and there are certainly other authors who would agree [with us about that]. So I believe that a major objective of the treatment is to help the patient modify internal object-relations, just as the transference-focused people do. But I don't believe that happens purely by interpretation. I believe that a lot of it happens from the relationship and the implicit relational processes that are occurring, that is driven optimal responsiveness to the patient.”

(CA-CSW-1, 6.09.2013)

Reframing Kohut as an object-relations theorist enables this practitioner to amalgamate this approach and Kernberg’s in his clinical practice.

Both “personalised psychotherapy” (introduced to me by one German clinician) and Benjamin’s interpersonal psychotherapy seek to locate some predictions for therapy within the diagnosis. Personalised psychotherapy’s idea is to develop a “metatheory” to guide treatment based on individual needs, based on the idea that formal diagnosis offers “no predictions for the therapy” and “that to uncover the therapeutic needs you have to recognise the underlying problems”:

“So what’s driving the patient to behave like this? What strains,
what stressors, traumatic experience, everyday burdens, are underlying it, and then I have to decide, can I work with the patient on these stressors or do I have to first care for his symptoms? And from that, I’d develop a therapy plan, so develop a therapeutic goal, and then check to see what methods I’ll apply. An approach (Ansatz) that focuses on the causes of the symptoms, formulates hypotheses regarding the causes, and checking if this hypothesis is verified when you work on them and if you can actually work focused on causes. That doesn’t always work. Sometimes it’s also necessary to intervene at the symptomatic level first.”

(DE-P-9, 12.03.2014)

Personalised psychotherapy is, however, somewhere between segregation and amalgamation in its approach towards the various models. An interpersonal approach offers advice based on the formal diagnosis, including suggestions as to when to use certain interventions, but is not metatheoretical. Rather, in keeping with the orthopraxy referenced before, it is multimethodological but all is underlain by a unifying theory. It should be noted that Benjamin (2003:386) also points out that “successful psychotherapies, no matter what their ‘school’ or underlying theory, can implicitly or explicitly be described in terms of these five stages” of correct intervention. Both methods point to individual factors in treatment.

(III) Treatment Indications: “But it’s typically such that the indication for a therapeutic approach isn’t determined by the patient’s requirements, but rather by the therapist’s knowledge”

What then of treatment indications? In the clinical literature, this matter is thoroughly discussed. The subject, however, came up indirectly in several interviews. For instance, one psychiatrist (DE-P-3, 13.01.2014) gave this answer to a question on the relationship between diagnosis and treatment: “Arbitrarily and by coincidence. Arbitrarily and by coincidence. And to be a bit more exact, through the
therapeutic method that the particular doctor has just learned. It’s regrettable, but that’s how it is.” He then explained, through comparison with ophthalmology and gynaecology, that psychotherapy has “very pronounced schools,” and concluded:

“An analyst ought to be in a position to say, ‘we’d be better off using CBT here, here one should do something else.’ … But it’s typically such that the indication for a therapeutic approach isn’t determined by the patient’s requirements, but rather by the therapist’s knowledge. And when you go to an analyst, they’ll say, ‘Psychoanalysis is indicated here,’ and when you go to a CBT therapist, they’ll say, ‘we do CBT here.”’ (DE-P-3, 13.01.2014)

The informant here identifies theoretical orientation as the factor linking diagnosis and treatment. Such direct influence is of course only way in which theory can influence how these processes relate. Two young Germanophone clinicians described how research influenced therapy in response to a question as to how one connected the “mean” finding (Mittelwert) to the individual patient. The first of these regarded herself 70% researcher and 30% clinician. She described manuals as a “guide rope” and providing “a few hints,” based on the example of depression:

“And there should be things exactly like that for other disorders like narcissism, and the therapist, that’s metaphorically working with these guide ropes, has the option to divert from the manual in the individual case in front of them. When the manual doesn’t correspond 100% with the patient’s needs, there are possibilities, so to say, to apply degrees of freedom and so to vary. I find that in practice it’s always in the therapist’s hands, yeah? Well, so to speak, they’ve got a guide rope, and beyond that they must respect the patient’s individuality of course.” (DE-CP-1, 18.03.2014)

In this telling, research informs the manual, which in turn offers the clinician clues as to how best to proceed. The practitioner’s interactions with the patient, however, determine whether or not (and presumably how) to deviate from the marked paths.

The other clinician stresses “means or research findings (Studienergebnisse)” as
“only guides” against which patients meeting “NPD criteria according to DSM-IV or 5” must be checked:

“First of all, I think that these studies are only hints that similar results or similar traits (Merkmale) could be present in the individual case, and then I’d have to look again, closer, ‘What does the mean discovered in this study mean in practice? What I can derive from this?’” (DE-CP-3, 19.03.2014)

She then lists a long series of hypothetical questions as to what real world impact this has, and the awareness the patient and their intimates have of this symptom. Answering these means “then [she] can contemplate whether or not [she’ll] tie it into the therapy.”

Taken together then, we see a broad pattern dependent on the therapist’s reflexivity and awareness of the immediate interpersonal situation (see Figure 7.1, below). There are multiple levels of interpretation, and the psychotherapist must balance two types of knowledge: experiential and scientific (Hunter 1991). Hunter (1991) and Atkinson (1997:173-181) suggest that there is a constant shuttling back and forth between the general and particular. Practitioners “are confronted with two aspects of rule use: that the symptoms must be mastered and followed, but also that experienced following of the rules implies an apparent ‘breaking’ of the rules” (Atkinson 1997:180). Manuals serve as rules, but are seen as less binding than scientific findings, but either can be overruled by the exigencies of the present patient. Atkinson (1997:183-184) reminds us that knowing when to break the rules is not simply a matter of experience, but can also be taught. Anecdotes and written or spoken case reports (Hunter 1991:Chs. 4-6) serve to increase the individual’s knowledge of exceptions. Supervision and/or intervision help to develop not only
this practical knowledge, but also feelings of mastery. Davies (2009) finds that such feelings have two preconditions: belief in one’s concepts and in “seniors perceiv[ing one] as proficient in [one’s] craft” (196). These methods allow a psychotherapist to confront the essential uncertainty of the consulting room with aplomb. Ideally, these patient experiences then help to guide further research, a point to be elaborated upon in the subsequent chapter. There is an implicit agreement here, however, that the therapist mediates the research results and determines their applicability in the specific situation.

Figure 7.1: How research relates to therapy

An elaboration of this point can be seen in a German psychiatrist’s response to a query on therapy integration:

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41 Joe Cortez formalised this diagram.
“We’d have to clarify which mechanisms of change are operant in these therapies, and contemplate what mechanisms, there’s no good way to say this, what therapeutic strategies are helpful in solving the individual patient’s problems. … I think it takes a multitude of therapies, and I think that good therapists have many tools and reflect on what they do, or at least have an intuitive feeling that something specific is needed for this patient, that you have to get away from this method and apply another, or that distancing and mirroring (reflektieren) are needed, or that now it’s about survival and now that’s on the agenda, say. It’s not very explicit, there’s no theory (Lehre) on differential use of therapeutic instruments, but many therapists do it. At least the better ones, the ones who aren’t as able always apply the same method.” (DE-P-9, 12.03.2014)

One of my respondents (DE-CP-2, 8.01.2014), who “in [her] heart [is] really a Gestalt therapist,” offered an instance of this flexibility. I asked her about a treatment that sounded like CBT, and she explained that she had “picked up a lot in the course of time, and I just check what makes sense in that moment.” The “poorly understood” and highly idiosyncratic natures of the “treatment matching” process were both confirmed by another informant (US-CP-2, 11.03.2014, email).

Research findings and theory have offered clues about how therapies effect change in a particular psychopathology, say borderline (Levy et al. 2006; Lynch et al. 2006; Wentzel et al. 2006). The therapist then has to juggle the immediate interpersonal encounter, knowledge of various therapies and how they are understood to operate, and ideally also those research findings not yet integrated. If haematology is any guide, folk wisdom transmitted across intellectual networks can coexist with potentially contradictory common knowledge (e.g. manuals or journal science, Atkinson 1995:145-146). Sometimes however a specific “clientele” will cause a clinician to blend in particular methods (e.g. with addicts, motivational interviewing and relapse prevention, CH-P-2, 20.02.2014).
In other cases, the indication is known, but there is a structural problem. One German psychiatrist pointed this out with group therapy:

“Well, if you apply strict indication-criteria then about 30-40% of all patients should be treated with group psychotherapy, because they meet criteria. For example narcissists or borderlines or social phobics. But our psychotherapeutic training that we do at institutes, cognitive-behavioural or analytic, is training in individual therapy, so that people don’t have sufficient competence to offer group psychotherapies. It’s a systemic failure (Systemfehler).” (DE-P-5, 28.02.2014)

One of Kahn-Hut’s informants suggested that group therapy is avoided because “it takes more of an investment in energy… than it does to do individual work” (1974:167-8). Research is needed, then, to determine how much of this is due to personal preferences and how much is systemic.

Other clinicians pointed to broad indications for pathological narcissists as a group. One psychoanalyst stressed the need to ease them into dependence on the therapist:

“…[W]hen you bring these individuals into such a substantial dependence, even in terms of time, three times a week, and they sometimes very quickly regress and then immediately there are dreams of crashing airplanes and towers that fall to pieces and then the patient stands up and says, ‘This is the wrong method.’” (DE-P-12, 17.02.2014)

He explained that this precaution is especially important with thin-skinned narcissists, “exactly because their projections are often malignant, their paranoia is just as grandiose.”

While this ‘dipping a toe in’ approach to therapy with narcissists is familiar to my informants, I must highlight the fact that this is almost a universal practice. I believe
this behaviour is indicative of a common object, pathological narcissism, to which all
these different methods minister. Therapy with narcissists is known to be slow, even
compared to borderline patients (US-CP-6; US-P-1), who are known by
psychotherapists to ploddingly progress (see e.g. Linehan 1993a). One American
clinician pointed out the need to “translate” presenting problems into a diagnosis.
She began by offering the example of depression as “a pretty straightforward thing,”
whereas troubles may arise with narcissism:

“...especially if the patient is very other-oriented, is very blaming.
... for example, if [the patient] is more preoccupied with how his
boss is functioning, it may take some time to gear the discussion or
the alliance building towards what he experiences, problems for
himself. And then from there on to translate that into some type of
diagnosis and what they need to work on.” (US-CP-5, 15.05.2014)

One Germanophone (CH-P-1, 22.01.2014) was able to roughly quantify, saying, “if
we’re talking about severe narcissistic disorder, it needs a longer, multiyear
treatment.”

We would expect such a statement from a psychodynamic psychiatrist, given that
psycho-analytic and -dynamic therapies have a reputation for dragging out. Even a
psychiatrist who worked more integratively (12.03.2014) suggested that
developmental disorders (Entwicklungsstörungen), such as NPD, “in [his] experience
a timespan of 2-3 years is normal for such a difficulty, self-esteem difficulties.” This
(potential) traumatic background led to certain technical considerations, and was
something one German psychoanalyst elaborated upon, because “[he heard I wasn’t]
asking about it”:

“And from that emerges a technical, treatment consideration,
namely that you have to watch that possible traumatic aspects get
treated, and there patients react very positively when they do
stabilisation exercises or some other type of training like DBT – these then are the building blocks that they can do something with themselves and they’re very relieved by that.”
(DE-P-10, 21.03.2014)

In general, then, some attention is paid to aetiology when treating narcissistic patients. Perhaps part of the reason DSM has not directly led to specific treatments in the personality disorders is because of its ‘atheoretical’ nature (see Chapter 8).

Benjamin (2003:4) suggests that to follow the medical model, there must be a postulated cause. But as we’ve seen, even explicitly non-medical treatments (e.g. DBT, Kohut’s self-psychology) always postulate a cause (e.g. fixation at an earlier stage of development, Kohut 1971). Interpersonal therapy (Benjamin 2003:143-147) offers “pathogenic hypotheses” for NPD. Pathological narcissism as codified in DSM (NPD) is argued by many clinicians to be a partial portrayal of the disorder.

Other therapies have accordingly attempted to trace the course of the different presentations (see e.g. Young et al. 2003:237-8 on different types of entitlement). One interviewee stressed that both the vulnerable and grandiose presentations were the result of “maternal deprivation” (Muttermangel) but had quite divergent treatment goals:

“The ones [Größenselbst] need more muffling (Dämpfung), so that they can dare to show their true face, and the others [Größenklein] so that they can stop getting attention through demonstrated weakness, rather that they actually also have the courage to have and develop their own abilities.”
(DE-P-4, 4.02.2014)

Treatment indications often came up in the discussion of malignant narcissists, who are regarded in Kernberg’s theory as shading into the antisocial. One practitioner (CH-P-2, 20.02.2014) stressed that “it isn’t like you’re either antisocial or not, rather
there are traits (Anteile), and I believe the capacity for empathy is very central here.” He continued on to state if a capacity for empathy was present, then patients could be “tutored a bit”, but that if “psychopathic” or “severely antisocial traits“ were present only a supportive psychotherapy was possible. We find here overlap between a sceptic and one of the psychodynamic practitioners he said possess “lower thresholds” for diagnosing narcissism:

“One can expect very little, and with some people, nothing at all, yeah? Above all, precisely those that have absolutely no subjective distress (Leidensdruck). So I’d estimate that out of a hundred people that’ve really got NPD, that meet the criteria I named, either experience inner distress or just legal trouble, that the problematic group is those whom one sees only when the courts are involved, but just lacking any personal, subjective distress. Prognostically that’s probably the hardest group, where hardly any treatments succeed, yeah? They just don’t get it.” (DE-CP-7, 21.02.2014)

The argument is not so much whether NPD or pathological narcissism exists, but rather where we draw its boundaries. To state the obvious, how we conceive of dimensionality dictates how we apportion and approach an object – in this instance, narcissism.

The intimate bond between conceptualisation and clinic is further seen in the answer of a psychodynamic psychiatrist when asked to give his opinion on how we might answer the “quasi-philosophical question” (his phrase) of where the limits of treatability lie:

“There’s a French psychoanalyst, he’s named Andre Green, and I’ve been very engaged with him recently and I think that there are concepts and also questions in connection to a – let’s say – identification with the negative, which is decisive as to whether one can treat certain people or not.” (CH-P-1, 22.01.2014)

Intellectual technology erects a boundary, demarcating what is treatable and what not
– as narcissism itself clearly shows, because Freud had argued that narcissists did not develop a transference and were therefore untreatable.

Some of my informants implied that the treatability border may be moving. The issue is that “pronounced antisocial pathology” is a “very contested domain where we have hardly any data” (A-P-2, 22.04.2014). Theoretical models and personal experience stop the gap until research can catch up with the clinic:

“Otto Kernberg would say that can’t be treated, a contraindication for psychoanalytic approaches at least. Others would say, ‘it can be done,’ but I’d say at minimum it’s a very, very important differential indication, namely because when pronounced antisocial traits are there, then you’ve got to account for that from the jump and you have a big problem with truthfulness and the patient’s lying. That means when I do a classic psychoanalytic treatment, and the patient’s not truthful, the treatment can’t help. So then you work with much more structured programmes, that target the delinquency rather than a deep-seeded personality change.”
(A-P-2, 22.04.2014)

Some clinicians also stressed that the individual’s resources had to be taken into account (e.g. US-CP-5; CH-P-1; DE-CP-3; DE-P-7; DE-P-9), including, for instance, “what level of access they have to themselves” (DE-P-8, 6.05.2014).

Conceptualisation is important in counting both resources (e.g. self-access is a resource in a psychodynamic treatment) and deciding how to sort through a bevy of difficulties. One (then) recent PhD summarised this thicket thusly:

“Clinically, oftentimes when people come in with severe personality pathology, they tend to have so much going wrong with them, there's so much impairment in their social functioning and their life functioning that the goal is really often times to prioritise targets, and then start working from there.”
(US-CP-2, 10.05.2013)

Related to resources are of course the severity of the patient’s symptoms, and whether some of the “social circumstances” (DE-P-8, 6.05.2014) can be ameliorated
or escaped. These considerations of stresses against resources, obduracy of these stressors, led to choice of treatment setting more than diagnosis (DE-P-8, 6.05.2014).

I conclude from what my informants have told me that there are two often entirely overlapping, but nevertheless distinguishable, types of severity: “It depends on how you define severity, whether it’s severity of illness or severity of difficulty functioning” (US-P-1, 22.05.2014).

Symptomology was mentioned by this respondent, but is not the most vivid description. In the context of a discussion on setting treatment goals and knowing when to modify them, one young American clinical psychologist told a tale in which he described using a manualised CBT treatment for a particular disorder as part of “a larger treatment package” (US-CP-2, 10.05.2013). One day the patient came in, and it became evident that she didn’t like that “the MD that wrote it did not just write it for her, like ‘Dear Miss B, blah-blah-blah-blah.’” This incident occasioned an epiphany:

“It's rare for someone to say like, ‘Why don't I have a personalised treatment manual?’ And when I explain like, ‘That manual is one part of a larger personalised treatment package that I'm developing for you,’ she just goes, ‘Yeah, not good enough.’ She would also talk about things, like she would (he laughs) she would talk about be going, having fantasies of going on Oprah, and she would be going – and this is a quote – ‘showing her that my life is worse than all those wretched people she has on her show.’” (US-CP-2, 10.05.2013)

We see here the way that “the narcissism… started to get in the way” of the treatment of the patient’s seemingly more pressing issue. While this individual typically utilised both psychodynamic (TFP) and interpersonal approaches, I don’t consider the emergence of symptoms or previously unseen issues over the course of
psychotherapy to be a psychodynamic quirk. Linehan (1993a; cf. US-CP-4, 3.05.2013), coming from the opposite end of Gunderson’s (2015) continuum, expressly states:

“Much of what goes on in any psychotherapy can be thought of as ‘assessment.’ That is, the therapist and the patient try to figure out just exactly what is influencing what; what factors are causing the person to act, feel, and think as she does; what is going wrong or right in the patient’s life and in therapy; and what is going on at this very moment. Where the therapist directs the patient to look for answers depends on the theoretical persuasion of the therapist.” (218)

Symptomology can also lead a therapist to suggest different methods for patients seen as alike because “they couldn’t really regulate power relationships” with one being given “a DBT-ish approach, in terms of just trying to help him contain his impulses” and the other being seen as “ripe for insight” (US-CP-4, 3.05.2013). Does a practitioner’s conceptualisation change, however, what difficulties they face in treating narcissists?

**(III.1) “[O]ne of her patients said, ‘If I was to get better, that means you win’”, or: Treatment Troubles**

Though it is hearsay, the above quote (US-CP-6, 7.06.2013) is a poignant and perhaps prototypical example of the difficulties clinicians faced in their work with pathological narcissism.

Unique here was one informant who answered a question about treatment difficulties with, “Generally not. I’m glad to and quite good at working with these patients” (CH-P-1, 22.01.2014). Another experienced clinician (DE-P-5) said that if one can
“establish a stable working relationship and attachment in the beginning phase… then psychotherapy generally works pretty well” (28.02.2014).

One clinician used the phrase “strong paradoxical reactions” (US-CP-2, 10.05.2013) rather than the more classically analytic “negative therapeutic reaction” (e.g. A-P-2, 22.04.2014). Two explicit reasons were postulated by the Austrian: (1) “because maybe they actually get depressed, because they experience that the therapist has such power over them that he can help them”, and (2) “but also unconscious, because they don’t want to allow the therapist to succeed” (22.04.2014).

Difficulties mentioned by only one or two informants will be briefly listed. A psychoanalyst (DE-P-12), for instance, pointed out that narcissistic men are often "unable to build up an idealised father-imago” (17.02.2014). Narcissists would try to be the best (and occasionally, worst) patients, according to one practitioner (CH-P-2), whereas for another they would merely give this impression (US-PP-1). One clinician suggested that they were a high suicide risk (DE-P-11, 5.03.2014), whereas another suggested this risk came after the bubble had been broken (DE-P-3, 13.01.2014). Narcissistic patients were also prone to create disruptions in group therapy (DE-P-6, 21.02.2014). Two analytically-minded practitioners referred to the “narcissistic façade”: one (A-P-1) said it was “extremely hard to really change” (20.02.2014), and the other pointed out how difficult it was to get behind (DE-P-4, 4.02.2014). Finally, malignant narcissists presented the possibly of reaching one’s own (or perhaps the overall) limit of treatability (CH-P-2, 20.02.2014).
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<tr>
<td>Idealisation and devaluation, particularly devaluation of therapist and therapy (A-P-1, US-P-1)</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Grandiosity is hidden (e.g. in masochistic narcissists, US-P-1), vacillations between grandiosity and vulnerability (DE-CP-4), or patients mistake shift from vulnerable to grandiose position or self-esteem stabilisation for cure (DE-CP-3, US-CP-9)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Avoidance behaviours: emotionally distant, defensive, intellectualising, rationalising, narcissistic retreats, don't want to think about the past; may have difficulty recognising emotions</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Manipulative or controlling behaviours (e.g. &quot;they need to be the ones who cut it off&quot;, US-CP-9, 6.06.2013), testing the therapist (sometimes even before first meeting, e.g. US-CP-3), exploitation (DE-CP-2, US-P-1), Doppelbotschaften (DE-CP-6), and &quot;dishonesty and antisocial traits in more poorly structured narcissists&quot; (A-P-2, 22.04.2014)</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Low motivation to change, e.g. unable to accept that they can develop further in Größenklein (DE-P-4, 4.02.2014)</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Countertransference issues e.g. irritability, anger; impatience (DE-CP-5); &quot;too critical of people with delusions of grandeur (Größenfantasien)&quot; (DE-CP-5, 4.03.2014); not accepting their idealisation as fact, US-CP-3, 2.08.2013; negative affect when narcissistic therapists fail to see advancement in their narcissistic patients, CH-P-2, 20.2.2014; &quot;differentiating my self (Person) from my therapist role,&quot; DE-CP-3, 22.01.2014; not mirroring patient's dismissiveness, US-P-1, 28.05.2014; &quot;it can get really boring to have to be an audience&quot; (US-PP-3, 9.05.2013)</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Need for special treatment, e.g. regarding payment (DE-PP-2, US-CP-11, US-P-1) or considerations regarding time (DE-PP-2, US-LCSW-1), or &quot;need to be asked for their opinion in, so to speak, a very special way&quot; (DE-CP-4, 12.03.2014)</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Irritability of patient, &quot;low frustration tolerance&quot; (US-P-1, 28.05.2014), e.g. &quot;sensitive to phrasing&quot; (US-CP-6, 7.06.2013) or vulnerability to shame when criticised (US-CP-3, 2.08.2013)</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Difficulty maintaining genuine relationships (e.g. &quot;Nähe-Distanz Konflikt,&quot; DE-1, 11.02.2014), sometimes due to lack of trust (e.g. DE-P-6, 21.02.2014)</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>&quot;[P]ulling the trigger too early on&quot; (US-CP-2, 10.05.2013) with interventions</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>
Managing the therapeutic relationship, e.g. avoiding "a mutual idealisation community," (DE-CP-4, 12.03.2014); or "you might not even know [the therapeutic alliance] is tenuous because it can be covered over," (US-PP-2, 17.05..2013); "not recognising the level of pathology" (US-CP-6, 7.06.2013); maintaining boundaries ("wasn't strict and structured enough for some of these patients," CA-P-1, 21.08.2013); "managing a variety of transferential offerings" (US-PP-1, 23.05.2013); the need to balance narcissistic supply and intervention (DE-CP-4, US-CP-4, US-PP-1); and the problem of unconscious needs (US-PP-2)

Pseudotherapy, pseudoanalysis, "parasitic relationship" (US-PP-1, 23.05.2013), or becoming a patsy for the narcissist

Externalising blame, sometimes resulting in narcissistic blindness ("so enamoured of his own image that he just gets rooted to the spot", US-CP-3, 2.08.2013) or an inability to comprehend that a behaviour is self-destructive (CA-P-1, 21.08.2013)

Alliance building

Slow, e.g. due to reflective functioning (US-P-1, US-CP-6)

Enter into conflict with therapist, sometimes carrying it outside the consulting room (e.g. online reviews, DE-PP-2, 3.02.2014)

Need to claim credit for anything positive (e.g. interpretations, therapeutic success)

Therapy goals rejected (e.g. as inauthentic, DE-P-2, 20.12.2013), unshared (e.g. US-CP-8, 20.08.2013), or patients formulate unclear goals (e.g. DE-PP-1, 11.03.2014)

Envy (A-P-1) or feel threatened by therapist's expert status (e.g. "don't want to hear anything, that they already know it all or know better," DE-CP-4, 4.02.2014; "you can never be right as a therapist," US-CP-1, 6.06.2013; become angry when challenged, CA-P-1; "they don't like being told, in the first couple sessions, what's wrong with them", US-CP-9, 6.06.2013 )

Inability of patient to tolerate dependence, vulnerability, helplessness, or weakness

Strong paradoxical reactions (e.g. rejecting help, or "when they become dependent on you, they become ashamed," US-CP-2, 10.05.2013)

(III.2) “Therapy is like planting a seed,” or: Gauging Success and Failure

Failure
One therapist (US-CP-5) gave a rather Biblical metaphor for determining treatment outcome: “Therapy is like planting a seed, and sometimes you plant a seed it ends up on the asphalt or in the sand, and other times it ends up on fertile ground. In therapy you plant a number of seeds…” (19.05.2014). Information gathered on what my respondents considered treatment success and treatment failure was similarly dispersed. Evidence emerged from several different questions: (a) how do you know when to terminate treatment, (b) inquiring about patients who’ve made a lasting impression, (c) sometimes in response to how many narcissists have you treated, and (d) asking outright what good and bad terminations looked like.

Some informants offered what at the time where bewildering portrayals of treatment success. A psychoanalyst spoke of “growing a capacity” or “core that was never there,” whereby the therapeutic:

“[J]ob is that of identifying with the person elements of their more unique self and something that is constant over time and trying to then form an articulation and a narrative that accounts for these various elements and how they hang together to form a person, how they amount to a self that is constant through time and internally consistent.” (US-PP-1, 23.05.2013)

His description of what this looked like (improved relationships, increased ability to express one’s feelings and limits, and being “much more able to establish boundaries with [various intimates], that seem respectful but not dependent on their approval”) only made sense later after I came to a better understanding of psychodynamic psychotherapies.

In terms of outcomes, this didn’t sound too different from what a schema therapist
(US-LCSW-1, 10.07.2014) said in response to a question about why she believed fundamental, but not structural, change was possible. Fundamental change entailed the ability “to develop this healthy observer side of themselves”, “to apologise and… mean it”, and “to actually feel” (10.07.2014). Rather than growing a core, ST takes “away this idea that at the core they’re defective” and “create[s] a sense of security.”

In another case (US-PP-3, 9.05.2013), a respondent described treatment success as being continuous rather than discrete. He gave the example of a “guy… who basically got up, said ‘Fuck you,’ and walked out at the first visit” as one of his only “complete failures.” People who “didn’t get over the thing that brought them in” could nevertheless be partial successes:

“Some people, [self-acceptance and developing an understanding they needn’t be perfect to be likable] will somewhat happen but they never really accept that so much and they still want to be perfect and they’re disappointed that they haven’t been transformed into a more perfect person by therapy.” (9.05.2013)

Suggestive of this is a story from a clinician (US-CP-10) who attempted to use DBT strategies to get an NPD client to collaborate in a smoking cessation programme: “I think he quit smoking, but we had this empirically supported protocol to go through and really no matter what I did, he was like, ‘I’m doing the protocol differently.’” (15.08.2013).

Clinicians sometimes indicated that success in psychotherapy was ambiguous at best. A psychoanalytic practitioner (US-PP-2) was often left with the “sense they still need and want something, I don’t think they know what it is” (17.05.2013). This

42 Paraphrase.
ambivalence is extended in a medical metaphor by a psychiatrist:

“Psychotherapy isn’t an operation where you actually say, ‘Now we’ve removed the appendix, and it will never cause problems again.’ Rather it’s an intervention at a particular time in a person’s history, and I don’t think anybody yet has examined if this really causes a lasting improvement.” (DE-P-1, 11.02.2014).

This may be why Stone (1993:321) states that “[l]ong-term follow-up has been considered the psychiatrist’s ‘microscope’ (S. Heller, personal communication).” He also reminds us that with a longer interval, “[outcome data] become more secure, but inferences about the efficacy of the original treatment become riskier” (ibid). It is here where sociology can contribute: follow-up studies by sociologists (e.g. Robins 1974) can better account for life events, and so can help psychiatry disentangle treatment and social effects over the life-course.

In other cases, clinicians reported not post-therapy success markers, but how one might predict the outcome based on early indicators. Many therapists pointed toward establishing alliance or rapport, but one psychiatrist added in “the significance (Präsenz) of the conflict for self-worth regulation” (DE-P-5, 28.02.2014). An integrative clinician (DE-P-9) emphasised a particular form of insight: “that therapy is training, a clarification, but that which one lacks actually has to come in real life” rather than the consulting room (12.03.2014). Improved “management of aggression, [and] of moral values” (A-P-2, 22.04.2014) stood out for explicitly referencing morality and hostility. One clinician (US-LCSW-1, 10.07.2014) mentioned what she termed necessary terminations, which came when patients were abusive or engaged in “dangerous, addictive behaviour that needs maybe more intensive treatment for a while before they can return to outpatient therapy.” While
Young (1995:181-182) is right in suggesting that “different doctrines can give different meanings to the same outcome”, I don’t believe this makes them incommensurable. The tables of success and failure indicators suggest that Young has merely bought into the narcissism of minor differences:

<table>
<thead>
<tr>
<th>Indicator(s) of success</th>
<th>GE</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-integration (e.g. &quot;growing a core,&quot; US-PP-1, 23.05.2013) or &quot;having more of a real-self that lets itself be separated from the ideal-self&quot; (DE-CP-4, 12.03.2014)</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Ability to tolerate affect and show it in front of a helpful other (e.g. crying in front of the therapist)</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>&quot;When the person’s expression of affects is appropriate to real threat and real safety.&quot; (US-CP-8, 20.08.2013)</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Interpersonal indicators (improved relationships, hurts others less, more empathy, increased autonomy, return to or advancement in work)</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Better able to articulate and (internally) regulate affect (for some clinicians esp. &quot;the ability to mourn or grieve something,&quot; e.g. US-CP-5, 19.05.2014)</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Patient understands and is able to recognise and combat own dysfunctional or maladaptive patterns, carrying on after therapy ends</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Less symptoms and/or in-patient stays</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Ability to tolerate own imperfections (esp. in Größenselbst, DE-P-4), e.g. &quot;dependence on attributes, on success and power, has somewhat lessened&quot; (DE-CP-4, 12.03.2014)</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>More realistic sense of achievement and goals (&quot;but can decide to reach for the stars if they have talents,&quot; DE-CP-4, 12.03.2014)</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Better able to tolerate losses, downturns, and ageing</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Learn skills for managing maladaptive patterns</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Therapy ends neither with mutual idealisation nor mutual devaluation</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Either patient or practitioner feel a plateau has been reached</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Making necessary environmental changes to avoid provoking narcissistic behaviours</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Noticing people outside oneself exist and growing to appreciate that they can enhance life</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Indicator(s) of failure</td>
<td>GE</td>
<td>NA</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
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<td>----</td>
</tr>
<tr>
<td>Early termination by patient (e.g. by own choice due to e.g. irritation, unwillingness to hold up obligations described before therapy begins; end of court-mandated treatment; being (re-)arrested; therapist misses several relationship ruptures/narcissistic withdrawals, leading the patient to believe the clinician doesn't understand him (DE-CP-5, 4.03.2014))</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>&quot;[S]imply unable to develop collaboration&quot; (US-CP-8, 20,08,2013)</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Early termination by practitioner (e.g. because patient wants physical altercation rather than conversation, CH-P-2, 20,02,2014)</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Rejects or feels threatened by working hypotheses, interpretations</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Fights, devalues or competes with therapist</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>&quot;[O]ne who can't find their way out of this drug-like, intoxicating opportunity to stabilise [themselves] and clings thereto, and also can't accept they have depressive, sad feelings within themselves&quot; (DE-CP-4, 12.03.2014), or &quot;that people continue to dwell in their grandiosity or vulnerability or lability&quot; (A-P-2, 22.04.2014)</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Mutual devaluation at termination</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Patient is unable to accept responsibility for own actions</td>
<td>1</td>
<td>-</td>
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(IV) Perceived international differences: “That there really are narcissists like in the book”

Only in four cases was I able to inquire about international variation, and two informants raised the topic independently. Given how Vallée’s (2011) study weighted inter- over intra-national differences, it is relevant to go through these stories individually. After telling me where in the US he’d been based, the psychiatrist whose quip introduced this section launched into how he saw the differences:

“And the narcissists there are much more pronounced, how the narcissistic criteria are phenomenologically much more obvious than here. That drew my attention. Yeah, I found that really amazing, how, so to say, that there really are narcissists like in the book [DSM]. (I laugh.) ... It wasn’t like that in [Germany] or here. So for instance, people who took supplemental testosterone, that
[said] with muscles and strength, I’m the strongest and the best here and so. So far more obviously this expansive narcissistic [disorder]. And here in Switzerland, where I’ve been the longest now, there are narcissistic disorders that constantly sacrifice themselves and that one wouldn’t recognise as narcissists, that present like depressives maybe, at first. And then the therapy doesn’t quickly improve, they receive antidepressants instead of psychotherapy for depression, and then somebody doesn’t suddenly get better. So somehow it just gets harder, and that only with time does the narcissistic difficulty (Problematik) crystallise out, also in relational problems with the team, or with the therapist. That it first emerges after some time, that would be the most impressive difference for me.”

(CH-P-2, 20.02.2014)

Some with experience both in Europe and the US (US-CP-5, 15.05.2014) echoed this sentiment, but restricted their comments to the region where they’d worked.

One German clinician had worked for a long time in the DDR (East Germany), and found it relatively easy to express the differences:

“In the DDR, the Größenklein presentation was much more common than the Größenselbst [presentation]. That’s because in the DDR, you were socially well advised if you were always a little needy (hilfsbedürftig), you played a bit dumb, ’I can’t do that, I don’t know that.’ So as not to get noticed. The real Größenselbst narcissists were always in jeopardy, so they couldn’t develop that way because then they would always be in danger of presenting their own opinions or to display themselves and then they would always be watched, by the law also (auch der Kontrolle).”

If we end the quote here, this respondent seems to suggest that pathological narcissism (and so by extension, other PDs) are socially constructed. We see however, that as Hacking (2000) described with childhood autism, the DDR narcissist’s “way of being is in part constructed” (121). What shapes it, however, is not the idea of what a narcissist in East Germany but two distinct ideas: communism’s collectivity-orientation, and the acceptability of playing dumb to receive help.
The remainder, however, suggests what Horwitz (2002:114-115, following Cullen 1983), refers to as the “structuring” of mental illness. He expounds that “[a]lthough general stress reactions may be rooted in biology, the symbolic systems of culture channel the highly generalised manifestations of stress into culturally specific and culturally recognised entities” (115). My informant continued:

“With Westernisation it totally changed. So many had to shift and compete professionally, then for some after the Change there were job application classes (Bewerbungskurse). There people were taught how to present themselves as better than they are. (I laugh.) The DDR citizen (Mensch) was used to saying, ‘Yeah, maybe I can do that, wait and see (I laugh) if I pull it off.’ Then in the Bewerbungskurse they had to learn, ‘Yes, yes, I’m the best, tops.’ (I laugh.) One could say the DDR cultivated the Größenklein, and the Western attitudes the Größenselbst.”

Both this respondent and his predecessor lend credence to Horwitz’ (2002:116) suggestion that “[i]f the structuring perspective is correct, many of the disorders in the DSM, no less than those in exotic (to us) societies, are culture-bound.” We can see, however, that “a coherent frame that organises experience in ways that a specific culture recognises” (ibid) comes not just from officially “[n]aming a disorder” (116), but also from how society channels behaviour.

Answering a question as to whether Freud's technical writings were still relevant some hundred years later, a psychoanalyst indicated that this structuring is understood with psychiatry:

'Construct (Gestand) of mental illnesses (Geisteskrankheiten) is different today, but "construct of course means that there's something firm underneath." Freud himself was aware that mental (psychische) illnesses are located in a sociocultural milieu.'

(DE-P-11, 5.03.2014, fieldnotes)
He seems to be speaking primarily of historical variation, his reference to ‘sociocultural milieu’ indicates that we can expand this to international difference. Psychoanalysis, then, can be unified with Horowitz’ structuring perspective. The plasticity of the outer expressions of mental illness was not limited to the Freudians, however. One respondent who gave seminars across the world (US-CP-3, 2.08.2013) offered further confirmation in an extended discussion of narcissism as “national style.” The introduction he gave to this explanation was that “one of the jokes you get from South Americans, maybe you won't consider it all that funny, is in South America, they define narcissism as, ‘that piece of Argentinian in all of us.’”

The French-trained German psychoanalyst pointed to the independence of French thought when asked whether his foreign training had influenced him:

“Yes, immensely. That was very clearly a centre of the psychiatric-psychoanalytic perspective in that time, no? And still today, no? First of all, even with the introduction of the ICD-10, the French put up a substantial resistance. And they preserved their French classification after the first attempt.” (DE-P-7, 13.02.2014)

In other words, the distinctiveness and depth of French psychoanalytic thought (or intellectual technology) drew this individual in, and has continued to guide his understanding since. We find some support here for the conclusion that “classification systems should also be considered ‘culture-bound’” (Vallée 2011:102), even the ostensibly international ICD.

One clinical psychologist suggested American psychiatry’s relationship to models had changed over time:

“I would say I’m an American, but I don’t think I represent American culture right now. I represent an earlier version of
America, I think, which was more respectful of developmental history, quite interested in empiricism but very respectful of theory.” (US-CP-8, 20.08.2013)

She seems to suggest here that amalgamation, segregation, and translation (cf. Cordner 2015) are operant even in the realm of science. This point is made clearer by an excerpt from later in the same speech segment: “Social science developed its own rules for science, and they are too often used as rituals in my opinion. They give data and numbers and Americans love that, but what do they mean?”

To some extent, numbers have become the *lingua franca* in science without much effort to explore them more deeply. There is a segregation not just of different treatment types, but also of theory and data: “I ask graduate students, ‘What is the difference between theory and data?’ They’re very simplistic. They’ll say, ‘Theory’s not true, it’s speculative and data is true.’ We have to go beyond that.” Earlier in the same interview, she suggested that the difference boils down to theory: “Europe, where as I say, people still like theory”, and America, which has come to rely on certain ritualised forms largely segregated from contaminating conceptualisation.

After some clarification, an Austrian psychiatrist depicted his national context as follows:

> “Hm, so the Austrian mentality, if there is such a thing, that’s naturally a bit of an unscientific expression, but I think that one often says Austria is an envious society (*Neidgeellschaft*). Envy is of course, also according to analytic theory, the central narcissistic symptom. So I think that plays a large part here, work with envy, so to speak. And otherwise in Austria we have a, how should I say, a relatively broad, loose *Psychotherapiegesetz*. So that means we’ve got a great many psychotherapists, but there’s hardly anyone who’s a specialist for narcissism. The demand for treatment would be extremely large, so I get endless inquiries, ‘Could you give me
therapy?” or so. It pairs with partnership problems, but also with professional problems. But the offering of people, of psychotherapists, is extremely low despite the high number of psychotherapists we’ve got in Austria.” (A-P-1, 20.02.2014)

What first draws my eye is his aside, “that’s naturally a bit of an unscientific expression,” which serves to distance him further still from this remark. The other thing we notice is that demand outstrips supply, as far as therapists willing and able to deal with pathological narcissism goes. My general impression is that this is true in both settings I studied, as narcissists are dubbed difficult patients.

(V) Discussion

If we take an eye to how diverse theoretical traditions manage the therapeutic relationship with pathological narcissists, we would anticipate difference. Indeed, that statement seems immeasurably obvious. The largest discrepancy might well be how the relationship is thought to function: whether it (1) serves as the foundation for, (2) is a vehicle for, (3) in fact is the relationship, or (4) some combination of the above. More important are the common factors of role induction, and being able to contain and tolerate the patient’s symptoms. Getting and keeping this population in treatment is a problem solved either by everyday means (gradually filling up a Beziehungskonto) or collusion (finding a foot-in-the-door problem, or “get more of what you want,” US-CP-3, 2.08.2013). Metatalk, as well as the establishment of certain emotional boundaries, both help to delimit therapy as a different type of interaction. Theory helps the practitioner to determine when and how to intervene (cf. Young 1995:211), and so makes the therapy relationship more predictable. Predictability is the first step towards control.
Schools saw themselves as differing in thoroughness, sequencing of interventions, and aim. I have also inferred from several informants’ answers that some of the differences are purely semantic. Therapeutic traditions compete not only in attention-space, but also in the marketplace (for students, patients, and sales of seminar seats and books). Self-interest therefore unsurprisingly plays a role in encouraging people to extol the virtues and uniqueness of their method, but there are also more innocent (and unconscious) motivations, namely that theory can sometimes obscure. We see here the minor differences of narcissism. The same mechanisms we saw operating at the boundaries of the various psychotherapeutic schools in diagnosis (amalgamation, segregation, and translation) serve the same functions here.

Curiously, what my informants’ observations of international differences reveal is not divergence, but the presence of a broad, underlying social process which Horwitz (2002:114-115, following Cullen 1983) referred to as structuring. I don’t propose some universal narcissistic disturbance which is then culturally channelled. Rather, pathological narcissism is itself a structuration of some broad genetic vulnerability (to interpersonal vulnerability, say), which is then structured further still by cultural milieux often thought of as being highly similar or the same. I see nothing anti-sociological in saying that mental illness is overdetermined and relies upon a combination of genetic, developmental, and cultural factors. We see depressed-looking Swiss narcissists and arrogant peacock American NPD patients for this reason. Theory, however, can cause some practitioners not to see the former as narcissistic.
Examining treatment indications (as represented in my respondents’ words) leads me to restate the circular and reiterative nature of psychotherapy: there is oftentimes a return to discovery and distinction (i.e. diagnosis). There is a shuttling between the patient’s present behaviour (i.e. the actual interpersonal moment) and the psychotherapist’s training – which I use as an umbrella term for research, theory, and any proposed mechanisms of change attached to specific interventions. General agreement exists as to the need to ease narcissists into treatment, or otherwise to build the motivation to change (e.g. ST’s leverage). This commonality suggests a broad family of self-esteem disturbances we might jointly call pathological narcissism. Theory again obscures fundamental similarities.

This double-edged nature of conceptualisation pops when we examine my informants’ answers on the treatability of narcissists with psychopathic traits. In the absence of firm scientific knowledge, theory helps to delimit what is improvable through psychotherapy and what is not. Hypotheses emerge from the clinical experience within a given theoretical school. Science, diagnosis, and treatment form a cycle, much as behaviour and insight do: one can enter at any point, and potentially effect changes in the others. My closing substantive chapter will deal with precisely these looping effects.
Chapter 8: Competition and its Discontents: The Mechanics of Psychopathological Science

“It was obvious that the sun rises in the east and sets in the west, so obviously the sun’s revolving around the earth. Well I think psychological theory’s at about that level now. It’s time to look at all of the data and study really all of nature, and to have theories that can be proven wrong. Like that vision of the sky just doesn’t fit. It just doesn’t.” (US-CP-8, 20.08.2013)

Science is a space of self-interest, tension, and turmoil. By the same token, consensuses and collaborations both large and small come about. NPD, if located in a credibility contest typology (Gieryn 1999), faces a two-front war: expulsion (15-16) and expansion (16-17). There is a definite struggle for "the legitimate power to define, describe, and explain bounded domains of reality" (ibid:1), what Gieryn calls epistemic authority. We’ve seen elements of expulsion earlier, but the case of psychoanalysis and NPD provides us a clear-cut example of how a conceptual tradition responds to attempted ostracization. In general, however, endeavouring to raze a rival’s scientific credibility seems a common strategy.

A slight hitch, however, is present. I predicted earlier that spiral movements from conflict to consensus (“in which substantive questions are answered and revisited at a higher level,” Shwed & Bearman 2010:818) travel in the same caravel as expulsion. The pattern surrounding narcissism, however, seems flat in the sense that “no coherent research agenda” drives the field (ibid:835). Yet contestation is not flat, but
Aside from the questions of therapy effectiveness and perhaps the factor structure of NPD, no research topics are cyclical, or “revisited without closure” (ibid:818). I suggest that this unusual admixture of consensus/competition exists because of an expansion effect. It is less that new psychotherapies for NPD appear like soot on a chimneysweep’s clothes, and more that new instruments do. A new measure is sometimes necessary, but such inventions also represent a chance for publications, attention, and possibly money. Self-interest enters here. But this is also a question of solidarity and morality: communities can spring up around tools, such as the Psychopathy Checklist – Revised (Pickersgill 2011b:80).

What about Gieryn’s final category, protection of autonomy (1999:17)? Autonomy is something of an issue for pathological narcissism as theoretical traditions want to get recruits and patients, and to sell books and training seminars (in large part because they believe they are helping people, and oftentimes, they are). Gieryn’s (1999) condition of outsiders attempting "to exploit that [epistemic] authority in ways that compromise the material and symbolic resources of the scientists inside" (17) doesn’t seem to hold here. While DSM’s rationalising (Kirk & Kutchins 1992:220-223) tendency intends to advance psychopathology as a science, it also limits discretion (ibid:49-56). Different relations to the manual arise, and several competitors (one prominent, the others obscure) vie for clinical and scientific use.

Social scientists (cf. Whooley 2014) suggest that there are some strains between the clinic and the lab. Examining my transcripts, I found three basic tensions raised by my respondents: (a) clinical vs. scientific logic, (b) clinical vs. scientific knowledge,
and (c) clinical science vs. clinical experience. Portraying these as dichotomies is somewhat disingenuous, but I feel it is a rhetorical necessity to demonstrate how my informants bear these burdens. The aim is again relational, to attempt to show the pneumatics that these pressures power. Our path runs from expulsion to expansion, and ends with autonomy.

(I) Ostracized Analysts? Science and Psychoanalysis

Psychoanalysis has long weathered accusations of being untestable or of not being demonstrably better than no treatment whatsoever. The impetus of the academy to ostracize the analysts is therefore hardly news. In speaking with psychoanalysts, their method occupied a unique position among all the other psychotherapeutic techniques I encountered: its relationship with science was unclear. The other distinguishing characteristic was that this association came up primarily in the Germanophone context. I am uncertain whether this is a genuine difference, or an artefact of my increased focus on science and therapeutic schools during my European fieldwork. While I make no claims about geographic specificity of this relation, I still feel it is important to explore. What then were these different bonds psychoanalysis had with science?

After half-joking that he thought that NPD was excluded because “possibly they didn’t want their own reaction style included in their book” (A-P-1, 20.02.2014), an informant qualified this statement further. He explained, “But this is clearly a psychoanalytic perspective and not a scientific one,” which led me to inquire what the difference was between them:
“Well, what does scientific mean? By scientific I mean the categorisations in the DSM-5 that are naturally dimensional and symptomatic, syndromal. Analytically you observe the genesis, the pathogenesis. That’s the difference. Pathogenetic perspective (Betrachtungsweise), and the now valid scientific one in the DSM-5 is a dimensional-syndromal perspective.”

Here they aren’t portrayed as antithetical, but they are seen as distinct vantage points from which one can observe psychopathology. We can see, even, how these could be successfully unified – pathogenesis reflects a causal understanding, and “dimensional-syndromal” a more descriptive or relational approach to mental illness. Some natives saw this differently.

As a lead-in to a question about differential diagnosis of PDs, I referenced an informant’s use of “wastebasket category” (DE-P-10, 21.03.2014) as a description of PDs. He interrupted me before I got to the question, explaining that formulation was “a bit cheeky” (etwas frech), and corrected this to “a so-called residual category.”

This reformulation led into a brief history lesson, whereby he explained that “PDs were ultimately introduced so as to not have to argue analytically,” and that previously this had been referred to as structure.

“I believe that the invention of the term [PD] goes back to the long tradition that’s meanwhile cropped up of not utilising analytic terminology in various words and nomenclatural phrases. Now that’s a bit funny, but also illogical. Because the tendency in diagnostic systems towards firm categorisations is something that comes out of internal medicine (Organmedizin), and that can’t work in that form in such a complex system as the psyche and the brain.”

Here we see the portrayal of an adversarial relationship between “diagnostic psychiatry” (to use Horwitz’ [2002] term) and psychoanalysis. Others saw these systems – or at least elements thereof – as at least potentially compatible. One
clinician (DE-P-8, 6.05.2014) said they “attempt to use a combination of descriptive diagnostic criteria and psychodynamic diagnostic criteria,” as well as “standard test instruments” in his clinic.

Viewing the problem from a more global perspective led still others to take this as a potentially fruitful union, which had not yet been realised. A psychodynamic psychiatrist (US-P-3, 25.06.2013, field notes) opined that ‘Studies of personality must consider two organisational levels, two developmental processes\textsuperscript{43}: the neurobiological and the subjective or experiential or symbolic.’ He elaborated that both camps ‘have some exclusive models,’ but stressed that no integrative model existed as of yet. I then asked him what he made of the National Institute for Mental Health’s Research Domain Criteria (RDoC):

‘The fashion now is simply for genetic determinance [sic]. There is this notion that if we can explain the neurobiology, that this will then translate directly into behaviour. Ultimately this research agenda is restrictive. “Time will show.” When one puts science in a straitjacket, in the long run one will recognise what is missing.’ (US-P-3, 25.06.2013, field notes)

I wouldn’t have initially expected this answer: It felt too balanced, too even-handed. In certain circles, the reputation of psychoanalysis is of a phalanx, a wall and roof of shields with spears in the fore. A possible example of this is another practitioner’s description of a prominent individual as “trained in a [particular] psychoanalytic tradition where you just come up with ideas out of your head and take them seriously, so [they don’t] have the commitment to operationalise” (CA-P-1, 21.08.2013). We might follow Fleck and “speak of nuances of [thought] style, of varieties in style, and of different styles” (1979:100).

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\textsuperscript{43} Berger and Luckmann (1967:47-51) make precisely this point.
Operationalisation came up when I asked two German researchers whether or not we could equate “implicit” and “explicit” self-esteem (see e.g. Vater et al. 2013) with “unconscious” and “conscious” in their psychoanalytic senses. One (DE-CP-1, 5.03.2014) explained that there was such a historical discontinuity, because “every author formulated also them a bit differently, and in the present that’s naturally measured by test instruments (Testverfahren).” Both (DE-CP-1, DE-CP-3) used the terms “automatic” and “overlearned” to define what they meant by implicit. One said outright she didn’t believe you could use “unconscious in the psychoanalytic sense” to “signify” implicit (DE-CP-3, 19.03.2014), whereas the other (DE-CP-1) said, “So to speak it’s a little bit open, if it actually is unconscious.”

The fit of certain types of testing and other practice was an open question for some psychoanalysts. One (DE-P-11, 5.03.2014, field notes) described manualised treatments and randomised trials as part of a larger compromise between psychoanalytic and mainstream (my phrase) science. Most interesting among his comments here was the cross-school comparison of the role of humanity: ‘In CBT the person is only a disturbance (therefore checklists and so on), whereby in psychoanalysis it serves as a measuring device.’ He also viewed randomised trials as a carry-over from drug trials whose appropriateness for psychotherapy was an open question (cf. Lakoff 2005:125-126). Further evidence comes from psychoanalytic training, where “ideas largely win approval through a subjective ‘self-testing’” (Davies 2009:122).
A German who self-identified as a psychoanalyst, doctor, and psychiatrist (DE-P-11) spoke about ‘case studies as the appropriate empiricism (geeignete Empirie) for psychoanalysis,’ and then explained that “psychoanalytic science” is something other than the everyday [science]’ (5.03.2014, field notes). When asked the difference between clinical reports such as Kernberg’s and scientific evidence, another psychiatrist clarified what he felt were the strengths of clinical reports:

"It's certainly shaped by clinical intuition and experience, and helps us better understand and describe this extremely complex reality but it's just not empirical. It’s a different kind of science, right?" (DE-P-6, 21.02.2014)

He closed by explaining that “by the operant scientific paradigms that we have now, there’s a shortage” of empirical research. The reference to “operant scientific paradigms” points to a historical or sociological contingency of fact (see Horwitz 2002:185 on case studies being considered scientific at the time of psychoanalysis’ inception). I mean this neither in an eternal progress nor a post-modern way. Fleck (1979) suggests that truth or facts are shaped by at least three factors: (1) the norms of the local and wider scientific communities, (2) the facts and thought styles already in existence, and (3) the interactions within a thought collective. Such “stylized thought constraint[s]” (ibid: 100, see 101 on fact) make sense within a thought collective and in a given period. The joke about physicists, “Assume a spherical chicken,” is an informal example of this principle at work.

Others saw case studies as different in a genealogical sense. A CBT clinician (DE-CP-3, 19.03.2014) suggested that “you could certainly describe [case studies] as empirical,” but went on to explain that although one couldn’t generalise from case studies, they were “the first option to enter into empiricism at all.” Others criticised
survey research, and suggested that a detailed examination of the conversation between a narcissist and therapist would be highly beneficial to our understanding (DE-CP-5, 4.03.2014).

What we have here is what one informant (DE-P-12, 17.02.2014) once called, “the empirical-hermeneutic uncertainty principle,” whereby “The better you are empirically, the story becomes semantically that much poorer, and when you can go more into detail, into the narrative, you unfortunately don’t have the quantification.” I didn’t realise until much later that an American informant (US-CP-2, 10.05.2013) had referred to “quantum psychiatry,” because either we can know where something is (prevalence), or how it works (course in comorbid patients of the type usually treated by therapists). Interestingly, we see again this emotionally ‘incongruent’ even-handedness in both practitioners.

The American stressed that “good N=1 empirical studies still require systematic observation, not just arm chair theorising based on one’s ‘impression’” (11.03.2015, email). He seems here to build on his earlier point that “psychodynamic or psychoanalytic thinking tends to go beyond the data” (10.05.2013). RDoC, in his opinion, was no better in that it too “goes way beyond any existing evidence” by purporting “all these are genetic and brain disorders” (ibid). Except perhaps on this last point, the understanding of science appears to overlap between US-CP-2 and DE-CP-1 (18.03.2014), despite their coming from different theoretical traditions. I’ll revisit this subject in the conclusion, but for now: “Ronald Coase reportedly said of institutionalism: ‘Without a theory, they had nothing to pass on except a mass of
descriptive material awaiting a theory or a fire’’ (Fourcade 2009:86).

I think virtually all my informants could agree with a psychoanalyst’s admonition that “you have to consider very closely, what method is appropriate to the situation in that case. But I’m not against empirical research” (DE-P-12, 17.02.2014). What seems incongruent is the final point. He (DE-P-12) distinguishes between “empirical-quantifying research” (which he doesn’t do) and clinical work. Another analytically-inclined informant (DE-P-4, 4.02.2014) contrasted his “empirical experience emerging from clinical work” and “research work.” There seems to be an unspoken agreement amongst psychodynamic practitioners that “Empirical… is used colloquially in scientific circles to mean systematic research intended to derive general principles about phenomena of interest” (US-CP-2, 11.03.2015, email).

(II) Double Definitional Dilemmas, or: “There’s the empirical camp, … and then you have sort of the more traditional, clinical camp”

In answering a question on the relationship between research, assessment, and treatment of NPD, a social-personality psychologist (US-SPP-1, 26.05.2014) described “the major challenge of the [PDs], where you have two major camps.” We encounter here a confluence of two definitional problems: (1) how do we define (and measure) narcissism, and (2) how do we define empirical and scientific and clinical? More crucial still, how do these concepts and social spaces relate? These questions are complicated by three basic tensions acknowledged by my informants: (a) clinical vs. scientific logic, (b) clinical vs. scientific knowledge, and (c) clinical science vs. clinical experience. Such an area is rife with shallow reefs, threatening to ground the
sailing sociologist. All these strains are involved with both issues. Definition and measurement will be explored using Gieryn’s (1999) notion of expansion (16-17) and Collins’ concept, fractionation (2000:131-133). Each of these tensions and questions will be discussed in turn, with some overlap. What then of measurement?

(II.1) Scaling the Self: Lumping and Splitting Narcissism

I call one commonly-mentioned problem lumping (cf. Zerubavel 1997 for a sociological use). How do we bundle (lump) and break up (split) psychiatric illnesses in order to treat and study them? In a conversation where the respondent hadn’t wanted me to use an interview schedule, we went from texts to discussing the work of a Berlin research group. I commented that I didn’t know if it was possible to observe (betrachten) a psychological illness without applying any theory. He replied saying that theory was always necessary, but that research could also go down blind alleys:

“[W]hen you do research on narcissism, then you’re trying to artificially make something an entity that actually concerns an aspect of being psychologically ill (vom psychischen Kranksein), or at least an aspect of PD, but not a stand-alone disorder. It’s really a waste of money to do that.”

(DE-P-9, 12.03.2014)

Another German (DE-P-1, 11.02.2014) contrasted the examples of dependent PD and cardiac arrest to draw a similar conclusion “the term suggests a unity that ultimately doesn't exist on the real level that we humanly observe.”

This comment immediately followed our discussion of how he establishes a good research base regarding diagnosis and treatment of NPD. In that context, he stressed that studies were difficult but possible, with the exception of psychotherapy research:
“… [T]his is just my personal guess, the therapy of narcissistic patients will never let itself be standardised and never be so unequivocally (eindeutig) defined that one principally applies only one therapy modality (Therapiekonzept) and can therefore examine it therewith, because the patients are simply too different, have too varied of complaints [and] problems.” (DE-P-1, 11.02.2014)

Diversity in narcissists is related to two further issues: the structural matter of how do we isolate NPD for study, and the question of how we split apart types or presentations thereof. Research into causes of specific disorders is possible, according to at least one informant (A-P-1, 20.02.2014). He stressed, however, psychoanalytic or psychological mechanisms rather than “neuropathological changes,” which was the first possibility he listed. One American (US-CP-11, 19.05.2014) answered a question on how he built a solid empirical basis for his work with NPD by meditating on the problems surrounding RCTs and other studies. He explained that it was difficult to isolate a “pure in terms of one diagnosis” population:

“In fact, I think this is in part inherent in our diagnostic system: that we have so many diagnoses that are not well-validated or not well understood, and so if we’re to adhere to using a system that’s pretty flawed to begin with and where there’s 300 some diagnoses in DSM, I think if we’re going adhere to that, it really is virtually impossible to get a group of NPD patients with nothing but NPD.” (US-CP-11)

What emerges is a ‘damned if you do, damned if you don’t’ dilemma, whereby one either excludes “most of the clinical population,” or one moves forward “knowing it’s going to be pretty muddy as to what the effects are and many other potential explanations for why we’re getting the results we are, these extraneous variables.” He explained that he tried to find a middle ground where you account for comorbidities, but use diagnostic interviews to make sure you are getting the right subjects.
Lumping and splitting necessitate fine, or at least accurate, distinctions. The question of how vulnerability and grandiosity coexist (or not) in the narcissist’s internal world is a prime example. One psychotherapist (CA-CSW-1, 6.09.2013) said:

“I think that's kind of an area of debate. Are we really talking about two subtypes, or are we really talking about two presentations, or two elements of the same core pathology? Two sides of the same coin, if you will.”

The argument that vacillation was “not the core of [NPD]” was justified with the following claim:

“Anxiety disorders, borderline disorders, they all show that sort of instability in the self-system. There’s nothing about that that’s uniquely narcissistic. Just if you’re narcissistic and you’re that vulnerable, you have that much neuroticism, you might be more likely to end up in a clinical setting.” (US-SPP-1, 26.05.2014)

Another clinician pointed to our own conversation as evidence of the lack of consensus “about the ‘delineating criteria’ for what healthy narcissism is, defensive narcissism, personality-disordered, pathological, [and] antisocial” (DE-P-12, 17.02.2014). Poor agreement about narcissism manifested in its extreme end with the belief that NPD was extremely rare. One such sceptic (DE-CP-7, 21.02.2014) said that outcome studies for NPD and experimental research on narcissistic irritability (Kränkarkeit) were desirable and doable, but would require screening out many people. The words of another clinician who saw narcissism as a spectrum were suggestive: "Right, put it like this: I see [NPD] in the classical sense as good as never" (DE-CP-2, 12.02.2014). We encounter again the underlying similarities despite what appear to be entirely incommensurate understandings of pathological narcissism.
We have returned to the realm of measures and models. Both the informant above and a psychoanalytic practitioner (CH-P-1, 22.01.2014) felt there was not yet an appropriate instrument in existence. They disagreed however on the form, one (DE-CP-7) favouring a questionnaire (*Fragebogen*) and the other wishing for “a really intelligent interview.” I feel this difference is due less to theoretical differences, and has more to do with the fact that they were answering different questions. With the psychiatrist (CH-P-1), I was inquiring directly about how we could improve assessment. The psychologist, in contrast, answered a query about the relationship between diagnosis, treatment, and research. Models do enter in when the psychiatrist specifies the interview be one “… which also doesn’t just orient itself toward superficial factors, rather [it] orients on more thoroughgoing relationship and self-esteem regulation, self-image, intimacy, such factors.” Somewhere between the two stood a German (DE-P-6, 21.02.2014) who stressed validity and the need for translocational agreement in an interview. This practitioner stressed that although narcissism provides ample room for study, “a central aspect of any such study is that one properly defines narcissism” through the widespread use of “good diagnostic apparatus.” He goes so far to refer to such standardised definitions and approaches as the foundation (*Grundlage*) for any research programme involving narcissism.

A general problem was the issue of “socially undesirable descriptions” (Benjamin 1987:56; cf. CH-P-1, 22.01.2014) in the DSM, and therefore in various other instruments. One way of avoiding this is to translate the criteria into interpersonal terms (see ibid:56-60). The argument, by my understanding, is that a good clinical
move (not shaming the narcissist by asking loaded questions) is also scientifically correct: if we translate thusly, then we’ll get more accurate responses. And these would in turn lead to better epidemiological counts, and more quickly being able to formulate a treatment plan targeting NPD. Other informants indicated that such translation might work for interviews, it might not work on self-report measures.

Even when there is a use of theory-specific terminology, as in the Young Schema Questionnaire, “frankly, with narcissists (informant laughs) the rate of return is very low on these inventories” (US-LCSW-1, 16.096.2013). Several ST practitioners (US-LCSW-1, DE-PP-2) highlighted that narcissists generally have a dislike for questionnaires. There was a general recognition that most inventories were not sensitive to vulnerable presentations or aspects of narcissism (e.g. DE-CP-3; US-CP-1). I was fascinated when one practitioner (US-CP-6, 7.06.2013) pointed out that International PD Examination (IPDE; Loranger et al. 1997) also asks the patient to provide descriptions of self and significant others. What this appears to be is an instance of the narcissism of minor differences. Examining the structural interview (Kernberg 1984:Chs. 1,2, see esp. p.29; Yeomans et al. 2015:84-90, esp. p.87) and the IPDE, one finds a broad concordance. Some Germans pointed to Deneke’s Narzißmusinventar (Deneke & Hilgenstock 2008), but were divided on its utility. One clinician (DE-CP-7, email, 9.03.2015) suggested the Single Item Narcissism Scale44 (Konrath, Meier, and Bushman 2014) as a means of assessing narcissism,

44 The item reads: “To what extent do you agree with this statement: ‘I am a narcissist.’ (Note: The word narcissist means egotistical, self-focused, and vain.)” (Konrath et al. 2014, Appendix S1). A seven point Likert scale follows, 1 being “not very true of me” and 7 “very true of me.” Curiously the pilot version “did not include a definition of narcissism but [they] found that including one increased the correlation between the SINS and the NPI” (ibid:3).
while recommending the Pathological Narcissism Inventory for vulnerable and the Narcissistic Personality Inventory (NPI, see e.g. Raskin & Terry 1988). Part of the reason for the expansion of tests is dissatisfaction with the NPI, which has been dominant: “[I]f you do a search, a lit review in the scientific literature for narcissism, nine out of ten papers are going to use the NPI to measure it” (US-CP-4, 3.05.2013).

The overwhelming majority of discussion about measures thus centred on the NPI, most of which fell on a range of rejection. We see Collins’ (2000) “creativity of fractionation as thinkers maximise their distinctiveness” (131). Opposition generated by the NPI gives scientists an opening, a point to enter attention-space. Take, for instance, this respondent’s summary:

“… [I]t's like what [Block?] called, I forget whether it's jingle or jangle, but narcissism has a jingle or jangle problem. So scores on the Narcissistic Personality Inventory I think reflect very little of what I'm talking about when I say narcissism. And yet, the bulk of the scientific literature uses that measure to operationalise this thing which they call narcissism. I see it as basically self-esteem, and I don't think narcissism and self-esteem are the same thing.” (US-CP-4, 21.04.2013)

A research oriented German practitioner agreed, saying she felt the NPI included “items that move more in a pathological direction” (DE-CP-1, 5.03.2014). Her point was that “different constructs are mixed up” (see e.g. Ackerman et al. 2011; Vater, Schröder-Abe et al. 2013). One psychiatrist (CA-P-1, 21.08/2013) stood apart from the other clinicians in that he felt “[t]he dimensional theory actually fits [NPD] perfectly, which is why the research on the [NPI] is very relevant to NPD.”

The lone research psychologist I interviewed (US-SPP-1, 26.05.2014) pointed to
“two basic camps”: “the high grandiosity ones, like the NPI,” and “the hypersensitive narcissism” for vulnerability. He then ran through the measures he felt occupied the middle ground:

“You get some scales that purport to measure both, like the PNI, which doesn’t really get at any grandiosity except for the stuff they take directly from the NPI, that gets at vulnerable. You have the five-factor narcissism inventory, which seems to get at both pretty well. And then you have these more clinical ones like the Millon or the SCID-II, which seem to get at grandiosity but usually have a little more vulnerability in it. They tend to be a little more vulnerable than the classical grandiose stuff. What am I missing there? The PDQ, which captures even a little more vulnerability”.

The similarity of the different measures was also flagged up: “But if you think about three basic ingredients of extraversion, low agreeableness, and neuroticism, they’re all capturing combinations of that.” Even in an area of expansion, we still see the minor differences of narcissism. What then of the validation process, so central to ‘hard’ measures?

Validation of measures assess, for example, “discriminant validity, convergent validity, predictive validity, and test-retest reliability” (Konrath et al. 2014:2). As “no knowledge possesses absolute warrant” (MacKenzie 1993:10), these instrument tests serve less to legitimate the measure in the eyes of both insurers and one’s fellow scientists. Validation therefore doesn’t curtail competition: “The NPI works really fricking well. But people don’t seem to like it” (US-SPP-1, 26.05.2014).

An odd couple was joined by their dislike of the NPI, or at least research applying the NPI to pathological narcissism: a sceptic using CBT (DE-CP-7) and a psychodynamic psychiatrist (CH-P-1). The latter described such research as
measuring “self-reported dominance, and nothing else” (22.01.2014). Our CBT colleague suggested that such research “has nothing to do with the disorder, rather it deals with students that are more or less self-assured, are arrogant” (21.02.2014). The difference is that the sceptic chided practitioners for “working with somehow diffuse, nebulous, analytic constructs that aren’t validated,” rather than seeking to find a way to scientifically approach them. He went further to suggest splitting was sorely needed in this case of conjoined constructs:

“And I’d tell them very clearly, separate – it has to be separated, right? So the disorder has to be separated from conflicted self-worth (Selbstwertkonflikt). Conflicted self-worth is treatable of course, and there are fantastic psychodynamic concepts for it, but that shouldn’t be confused for NPD.” (DE-CP-7, 21.02.2014)

It is noteworthy that he flags these psychodynamic concepts as useful, but at the same time, they are set apart as dealing with a different clinical phenomenon. Both agree that narcissism is distinct from high self-esteem, but they differ on how and where we draw the boundaries.

Thus far we’ve only encountered validated instruments which have been probed statistically, and none of the “soft signs” (behavioural signs, emotion evoked in the therapist, etc.) one informant highlighted (US-CP-10, 15.08.2013). Clinicians of virtually all schools used both “soft” and hard signs. A major difference, at least among my German informants, was the relative emphasis placed on the different types of evidence. The two practitioners skewing psychodynamic who used both (A-P-1, DE-P-10) were divided. Clinical judgment came first for the Austrian: “… but naturally you can never give a diagnosis with a test alone, not even a PD diagnosis. Tests are always just aids (Hilfsbefunde), with which one props up (untermauert) the...
whole, or maybe even falsifies [it].” The other stood a bit closer to the CBT practitioners, one of whom discussed “gut feelings” in diagnosis (DE-CP-1, 5.03.2014), but stressed that one needed to explore these further. “Securing” (abischern) a diagnosis is important “in a clinic that values being taken seriously” (DE-P-10, 21.03.2014). Scientific tests – meaning those validated in peer-reviewed studies – are seen as legitimating the clinic’s activity, irrespective of theory.

Despite the existence of a validated version called the STIPO (Structured Interview for Personality Organisation), most TFP practitioners I spoke with stuck with Kernberg’s structural interview (e.g. US-P-1, DE-CP-4). All psychodynamic practitioners were alike in their heavy reliance on transference and countertransference, but more classic psychoanalysts tended to be still more emphatic:

“I don’t apply any tests, but rather the measuring instrument for the air pressure is here (he knocks on it) and the measuring instrument for humans (he begins to laugh), that’s me myself.”
(DE-P-12, 17.02.2014)

He then used the English word “permeable” in further explaining how he diagnosed. What stood out to me was the difference between the CBT and DBT clinicians I interviewed in North America. DBT is often described as radically behavioural, but the DBT practitioner I spoke to was wary of what she alternately called “behavioural” or “clinical observation(s)” (US-CP-10, 15.08.2013). A CBT clinician said “assessment is key, but assessment doesn’t always mean testing, a [PD] inventory, something like that” after giving this example:

“I had a patient come in wearing a red, tartan-plaid three-piece suit. Now you have to picture this adult male wearing plaid pants, plaid vest, plaid jacket, and the only thing, I mean I thought to myself,
he's missing are batteries in his pocket to make it flash on and off. (CFD laughs) I mean, is there a question that he's histrionic? I mean, I have no question about that, it's pretty obvious.”

(US-CP-3, 2.08.2013)

In this instance, the CBT practitioner is more behavioural than his radical counterpart. The most recent edition of *Cognitive Therapy for Personality Disorders* (Beck, Davis, & Freeman 2015) describes use “[t]he patient’s emotional reactions to therapy and the therapist” as a source of information about the patient’s cognitive distortions (108). CBT’s use of “‘transference’ reactions” is therefore strikingly similar to that in psychodynamic psychotherapies. Countertransference is, however, seen exclusively as something “you've got to be really careful of” (US-CP-3, 2.08.2013) rather than a potential source of information as well as distortion.

Sometimes research enabled clinicians to better understand transference. One psychoanalytic clinician (US-CP-5) pointed out that she came to see difficulty in alliance building as self-protection, “as a way of balancing vulnerability and difficultues” (19.05.2014).

Measures are of course intertwined with the empirical. As we’ve seen with psychoanalysis, there is some dispute as to what ought to be considered evidentiary. A key example from my data is the example of COP and its underlying model of PDs. One research-oriented clinician said the following:

“There’s the model of double interactional regulation (*doppelten Handlungsregulation*) from Rainer Sachse, anyway. I find that very good because the themes (*Fachleiten*) of grandiosity and vulnerability are theoretically very well articulated (*aufgearbeitet*), and you can use that well in therapy. But it’s not empirically supported at all. There aren’t any studies on it.”

(DE-CP-3, 22.01.2014)

My lone COP respondent (DE-CP-6, 25.02.2014) described studies (seemingly done
in-house) of different types of narcissists and their respective therapeutic success and early termination rates. In general, the clinic he worked in tested all patients both before and after therapy to measure change. Significantly, these results are unpublished, or thought to be so by my informant (DE-CP-3). Outside scrutiny (peer review) and statistical confirmation make the difference, although these too are potentially contestable.

The COP clinician (DE-CP-6) was also one of the only respondents to describe the fit between assessment, treatment, and research as “relatively narrow.” His focus is on his local setting rather than the field of researchers. Conceptualisation is here relatively central. A TFP practitioner answered a question on the difference between a report from clinical experience and scientific evidence thusly:

“You’d have to look over individual studies here, because the studies themselves consider many different things, with which theoretical school they associate (mit welche Schule denken sie dabei), for example…”

(DE-CP-4, 12.03.2014)

Interestingly another clinician, "with a fundamentally psychoanalytic point of origin, but with additional CBT training" (DE-P-5, 28.02.2014) was able to say that the “main difference” was “validity.” I asked a young clinician about the difference between a clinical finding (Befund) and an empirical case study, and then immediately inquiring if we had to do a meta-analysis of multiple individual case studies is necessary before it counts as empirical. She (DE-CP-1, 18.03.2014) rightly corrected me, saying “those are different methods that you’ve just listed (aufgezählt)” with different “quality standards (Gütekriterien)”. The phrasing of her answer was telling:

“… [F]or example, at universities, in contemporary psychology
only studies are carried out. No case reports (Einzelfallberichte) or case documentations (Falldokumentationen), the reason being that these methods clearly have certain quality standards regarding, let’s say, generalizability I’d say are better established, right?” (DE-CP-1, 18.03.2014)

I followed up, asking about the problem of the mean. She said that it was possible that a study wouldn’t be generalizable to an individual, that “the individual case study carries over mainly only to the individual case”. She endorsed classical scientific values of reliability, validity, and replication in this speech segment. While she did go on to suggest multi-method approaches, a case report does not rise to the level of a study because of its divergent standards.

In contrast, an American (US-CP-4, 2.03.2015, email) agreed that universities channel knowledge production, but his phrasing (“institutions reinforce some activities more than others”) was less neutral. He directed us towards two causes for the dearth of empirical case studies: the institutional contingencies cited above, and opportunity cost – “there is not enough time to do everything well”. Overall, his concerns were pragmatic:

“We all have different perspectives and sources of expertise and certainly nobody knows enough at this point to shut anyone out, but for me personally, I find it quite valuable to balance the applied and basic. I do think idiographic science has as much to offer as nomothetic science, all things being equal, so a well-done empirical case study does have substantial value.” (US-CP-4, 2.03.2015 email)

In short, it is about systematically creating knowledge. His references to “basic” and “applied” science (roughly the same as nomothetic and idiographic) are unique among my respondents – no one else divided up science this way, although one informant (US-CP-9, 6.06.2013) mentioned an “idiographic” component in a clinic’s
research/treatment protocol. Combined with his earlier statement, “I think theoretical orientation is really overblown” (3.05.2013), we see here a commitment less to a school or a method, and more to what works and is done well (cf. US-CP-2, 11.03.2015, email). His ultimate commitment can best be summarised in his own words: “But in the end, the integration of science and practice seems to me to be the key” (US-CP-4, 2.03.2015 email). Clinical observation, if systematic, could be scientific – but it wasn’t necessarily so.

Others didn’t see clinical observation as necessarily different in kind from scientific research. One informant who described himself secondarily as a psychoanalyst (A-P-2) said there was “a continuum of grades of evidence, just like in the [treatment] guidelines” (22.04.2014). At the top were RCTs with a manualised treatment, as these were reproducible. He warned against neglecting clinical experience, however:

“And I find that it’s always important not to play one against the other, so quantitative studies against clinical experience, rather I think it simply needs both to develop and implement a therapy modality (Therapiemethode). In between randomised-controlled studies are also needed, because otherwise you don’t obtain this certainty (Sicherheit) and otherwise the insurers (Kostenträger) and the politicians wouldn’t be convinced.” (A-P-2, 22.04.2014)

What this informant appears to express here is a belief that there is no fundamental split (where one “play[s] one against the other”)

Different understandings of (validly) empirical are clearest in several German respondents’ references to the (non-)existence of studies on pathological narcissism. One clinician felt there were no evaluation studies because self-esteem problems were being confused with narcissism:

“There’s absolutely no research on [NPD] because the assessment
(Diagnostik) is unreliable, is invalid, right. And worldwide there isn’t one single evaluation study of [NPD]. You must imagine this. After a hundred years of Freudian narcissism theory, not one, right?” (DE-CP-7, 21.02.2014)

Another CBT clinician (DE-P-1, 11.02.2014) pointed to the work of the Berlin group, but then pointed to a lack of a particular type of study: “When I set out from a purely empirical standpoint, to my knowledge there is not one empirical therapy study on narcissism.” Finally, a third point of came from COP, itself in the CBT lineage, where one practitioner (DE-CP-6, 25.02.2014) said he knew “easily 80 empirical studies.” He went on to state that, “Here you see that principally I believe between 80 indicators, empirically valid indicators for narcissism exist.”

What causes the difference? We can explain the sceptic in his own words:

“95% of all clinicians in Germany, and probably also in the USA, define narcissism only with psychoanalytic criteria, that means that these people have a self-worth disorder (Selbstwertstörung). And then they’re irritable and they count, so to speak, as narcissistically disturbed (gestört) in the psychoanalytic sense. That’s an absolutely incorrect ‘labelling’, right?” (DE-CP-7, 21.02.2014)

The distinction lies in the definition of narcissism here (cf. US-SPP-1, 25.05.2014), but what about the other two? Models are perhaps bit players here, since the psychiatrist (DE-P-1) adheres more closely to the DSM. From the seemingly poor fit of theory as an explanatory variable, I take it that the difference must lay in divergent definitions of ‘empirical.’ My understanding had been that, “Empirical just means it can be verified by observation or experience, and not by pure logic” (US-CP-2, 11.03.2015, email). Some evidence of this is found in the psychiatrist’s portrayal of developments in psychotherapy. He describes how science legitimates

45 English in original.
psychotherapies born from clinical experience:

“But you have to say fundamentally that actually, in my eyes, the psychotherapeutic developments of the last decades, let’s say now [ST] and and and, are all together not on the empirical standard rather they were ideas that were doggedly attempted to be validated empirically, and the results of this validation aren’t exactly *phenomenal* in our estimation.”  

(DE-P-1, 11.02.2014)

We encounter here again this perceived divide between clinical experience and what is empirical or scientific. In the next section, we shall address the way my respondents thought of this gap.

**II.2 “Clinical logic is different than scientific.”**

Roughly three of my informants suggested sociological reasons for the state of affairs between the clinic and the lab. Each of them, however, indicated a different relation. For instance, the respondent whose words head this subsection saw it as a difference of thought styles or logic:

“Clinical logic is different than scientific. In clinical logic, you search for evidence, pulling out everything that supports an intuitive preconception. … A scientist would say, what speaks against this hypothesis, and they’d postulate that it could be something else… Clinically you maximise evidence, and scientifically you go against the grain and falsify.”  

(DE-P-3, 17.02.2014)

The “gold standard” of this clinician’s “scientific life” had been “clinical experience, theory construction, and empirically testing the theory” (DE-P-3, 17.02.2014). He still did steps one and two, but the costs of step three had become overwhelming. Generally, these factors suggest two different epistemologies: one more hermeneutic and inductive in the clinic, and the other more positivistic.

Others were more explicitly sociological, pointing to various groups either whose
ideas were in competition, or who had different means of relating both to one another and the associated social worlds. For the research psychologist (US-SPP-1, 26.05.2014), there are literally “two major camps”: “empirical” or “clinical,” divided by different positions on dimensionality (where “generally [clinicians will] see it as a bit more of a disease model”), and on where vulnerability falls in narcissism. This depiction seems to be caricaturizing, and thus simultaneously a moral and empirical claim: our method (and thus epistemology) is better than theirs.

A third set of positions opens up the possibility of shifting between or even hybridising roles, as what differs are the relations to research and clinical practice respectively. A COP practitioner (DE-CP-6, 25.02.2014) listed three groups: (1) “practitioners, who only let themselves be guided by practice, and hardly take research findings into consideration,” (2) “scientific groups, who almost only take science into consideration, and who barely have any practical experience (Praxiserfahrung),” and (3) a hybrid group who “bring practical questions into science, and science into practice”. He limited this scheme to Germany, but I feel it can be extended to all countries I studied.

Two related positions emerged from my interviews. First, while several Americans fell into this third group by my definition (e.g. US-CPs-1, 2, 4, 9, and 11), some (e.g. US-CP-6) actively referred to themselves as “scientist-practitioner[s].” I asked two research-oriented Germans (DE-CP-1 and -3) whether they felt they were scientist-practitioners. The term was at best alien: one began her answer, “I haven’t really thought about it” (DE-CP-3, 19.03.2014). With DE-CP-1, I outlined the above
threefold division in my own words after an initial attempt to clarify the question didn’t seem to have much impact. She opened her ultimate reply by saying, “my primary occupation (Hauptbeschäftigung) is roughly about 70% science, but to 30%, I’d say, I’m practicing clinically (praktisch tätig)” (18.03.2014). Why this term is North American, but these distinctions ‘click’ with Germans, I cannot say – but the divergence may be relevant to future research. Both of these Germans, however, stressed that an interrelation between research and practice was desirable and something they personally strived for.

In our first interview (13.01.2014), the informant who introduced this problem to our attention (DE-P-3) pointed out a different way sociological factors impinge on science. We saw in the previous chapter his assertion that the tie between diagnosis and treatment was largely defined “through the therapeutic method that the particular doctor has just learned”. Perhaps due to the way I formulated the question, he seemed to largely equate diagnosis and treatment. I believe, however, we can derive two things from this possible misunderstanding: (1) individual practitioners can switch between scientific and clinical logics, but seem to be bound by their conceptual commitments in the moment, however mercurial they may be; and (2) as such, science (particularly effectiveness studies) could be limited by theory.

An example of point (2) could be found in the sceptic’s words above (DE-CP-7). Broadly speaking, four informants (DE-CP-1, DE-CP-3, DE-CP-7, DE-P-1) spoke of a relatively poor, if not absent, link between assessment, treatment, and research. All four were united by feeling that the present definition or model of NPD was in some
The lack of empirical exploration of the “theoretical roots” of narcissism meant that there were “no guidelines, [and] relatively few books and syntheses (Zusammenfassungen)” (DE-CP-1, 5.03.2014). Such a lack was problematic because “manualised therapy grounded in research is superior to an unstructured therapy”. What it comes back to is the definition, a point explicitly made by another informant (DE-CP-3, 22.01.2014). One psychiatrist (DE-P-1, 11.02.2014) said, “There’s almost no jump from empirical-psychological research to a treatment model,” excepting a single monograph, and felt that these “could be very, very fruitfully applied for this.”

Crotty (1998:4) suggests that social research consists of four elements, each building on the last: epistemology, theoretical perspective, method, and methodology. We begin with real-world problems and method, but our work is suffused with theory, and deeper still, certain assumptions about the nature of knowledge (ibid:Ch. 1). If we examine practice, I’ve argued, there is a blending of knowledge in the individual practitioner – anecdotes, theories, experience, and research (Hunter 1991). Therefore, one might suggest, there is a falsity to this distinction, or at least, an internal contradiction. Our scientific understanding of psychopathology is predicated on clinical experience, as suggested by the idea of “a continuum of grades of evidence” (A-P-2, 22.04.2014). There is then a possibility that the opposing groups choose to continue the conflict, in order to create niches in attention-space. In other cases, practitioners may simply be unaware that a positivistic and an interpretative understanding of psychopathology are incompatible.
Training and supervision also came into play with several informants. For some (e.g. US-P-1, 22.05.2014), research findings could be integrated into training in order to help novice therapists avoid certain pitfalls with narcissists, such as “mirror[ing] the patient’s dismissiveness”. Two more analytically-oriented therapists (DE-CP-4, DE-P-10) saw supervision as filling a role that research couldn’t. In both cases, it seemed to be about interactional knowledge. One (DE-CP-4, 12.03.2014) explained that, “I believe that the necessary research, shall we say, just doesn’t go into the detail of the interactional patterns the way I’ve just described them to you.”

Knowledge of how “you handle countertransference” was what research, however valuable, couldn’t provide. Outstanding here was a then-student (US-CP-9), “psychodynamically oriented primarily” (6.06.2013), who felt that scientific knowledge and clinical experience were “somewhat separated in practice, but ideally good training integrates them both” (2.03.2015, email; cf. Castonguay et al. 2015, which describes such a programme).

Three Americans differently stressed methods in discussing the relationship between scientific knowledge and clinical experience. Some believed certain tools were being excessively or insufficiently applied. Generally, my informants advocated for dimensional models of PDs, but there was nuance here. It is problematic “trait models and dimensional models that are based on peoples’ self-reports really drive the way in which we think about and define what psychopathology is” because traits are “not the thing that brings people into treatment” (US-CP-11, 19.05.2014). He described factor-analytic and statistical modelling work as “all well and good” and having its uses, but that “we’re really in some ways letting the tail wag the dog.”
The field “must pay more attention to what the clinical experience is, and not the clinical processes that unfold” in order to “[help] us to really come to understand pathology” (US-CP-11).

In contrast, an assessment specialist (US-CP-7, 2.03.2015, email) suggested that the problem was that clinical practice was insufficiently guided by scientific evidence:

“Too many people think that clinical experience is a separate form of knowledge from scientific evidence. In an ideal world, it wouldn't be, or at least not that different. In the real world, too much clinical experience is unsystematic, which is the antithesis of scientific evidence.”

She reiterates the idea that it is systematic observation which makes science. What this misses, however, is that clinical practice involves shuttling back and forth between one’s stock of knowledge and the case one confronts (Hunter 1991). Scientific knowledge, clinical experience, and anecdotes (ibid. Ch. 4) amalgamate in the practitioner’s mind. It is more likely, in my opinion, that clinical experience favours the use (and often overuse) of particular tools is less a question of being systematic and more one of solidarity. There is not a community for eccentric practitioners, but there do exist collectives for assessment specialists, CBT, TFP, and so on. Science too has its illogical and unsystematic moments (see e.g. DE-P-10, 21.03.2014 on “the long tradition … of not utilising analytic terminology”).

Our final informant (US-CP-1) stressed the complexity of clinical phenomena, and implied that science lacking “all the means” to study them was “an old story”:

“Well I think they’re overlapping, and it really is more complicated than either ‘they’re separate’ or ‘they’re the same’. I think much of clinical knowledge can be integrated with scientific knowledge, but some of our clinical knowledge is based on – I would say –
intellectual structures that we currently don’t have empirical methods to optimise the scientific method, to employ with them. I do believe scientific knowledge and clinical knowledge should be integrated, but I also think clinical phenomena right now are more complex than scientific methods allow us to completely measure and operationalise. So we have to integrate where we can and continue to develop methods…” (US-CP-1, 19.03.2015)

He discussed this in the context of ergodicity, the concept that between-person correlations will be reflected in within-person results: “So between persons, these [Five-Factor Model] dimensions are independent or orthogonal. But within-person, they’re not.” This “idiosyncratic part” of correlations and variation within-person was one such area where new methods were being developed (e.g. Roche et al. 2014).

We can therefore list ten practical problems with researching pathological narcissism:

(1) Difficulty finding subjects, either because NPD patients rarely voluntarily seek help (e.g. A-P-1, US-CP-3), or they’re in prisons and have antisocial traits (DE-P-5). Scientists are self-interested, and without competition, there is not much reward to scraping together subjects for a study.

(2) Lack of “a strong advocacy base” (US-P-1, 22.05.2014), meaning that there is no political push for increased research funding and for insurers to reimburse for NPD.

(3) “[B]orderline’s more severe” (US-CP-4, 3.05.2013) or also, “the suffering of the narcissist is less evident to the outside world” (US-P-1, 22.05.2014). Put cynically, self-harm and revolving door psychiatric admissions catch our attention more than someone who’s been fired dozens of times.

(4) It is found largely only in Western societies (DE-P-5, DE-CP-7), or “it becomes a national style” as in Argentina (US-CP-3, 2.08.2013). It is then either a culture-
bound syndrome or oftentimes an acceptable form of relating to one’s self.

(5) Difficulties in getting and subsequently holding them in treatment (e.g. A-P-2, US-LCSW-1), which represents a complication of (1). If there are already relatively few in treatment, and those individuals are hard to retain, there is a paucity of successfully-completed cases. Negative results are informative, but to become more clinically meaningful, they must be compared with more-or-less effective outcomes.

(6) A different skill set might be required for certain details: “[S]omething like how I deal with [NPD] is really hard to describe scientifically or on an empirical level” (DE-CP-4, 12.03.2014; cf. DE-PP-2, 3.02.2014). Social science could be beneficial here. While some CA studies do aim to do this sort of description, others go in not sceptically, but out for blood (Hutchby 2002, 2005).

(7) Poor definition or model (e.g. US-CP-4, DE-CP-7).

(8) Cost of instruments and co-investigators (DE-P-3, 17.02.2014).

(9) Lack of appropriate tools and/or under-/over-use of certain tools.

(10) Finally, problems with the understanding of theory, at least in the American context (US-CP-8, 20.08.2013).

On this final point, some elaboration is needed. The informant gave an anecdote where graduate students described theory as false and data as true. She was a defender of theory, and also one of the only Americans to mention falsification. What she does is raise the issue that to think in this way is overly simplistic, to generate a false dichotomy. She makes essentially a Kuhnian or Fleckian point (theory guides research), but combines it with Popper. For her, conceptualisation simultaneously propels and steers research, with falsification sometimes switching
I largely agree – my lone modification would be to swap competition for falsification, as “[i]deas do not succeed in history by virtue of their truth, but by virtue of their relationship to specific social processes” (Berger 1965:32). Overall, these ten points centre on conceptualisation, self-interest, and competition as these “specific social processes.” My emphasis is on competition, which doesn’t contradict her comment that “reality’s my best friend” (US-CP-8, 20.08.2013).

Theory acquires an “obdurate quality like that of the banal world” by being “a real focus of attention and, over time, of consensus within a real network of scientists” (Collins 2000:871). Ideally, this is the point where falsification would dictate consensus.

But theory choice is dictated by “competitive philosophical networks”, which is the half of Collins’ “formula for high-consensus science” possessed by pathological narcissism (ibid:538). We want not for empiricism, but “a fast-moving genealogy of research technologies” (ibid) with which to carry it forward. The proliferation of new assessment tools only serves only to further fracture attention-space: it benefits the school or individual, but does not generate a genealogy. Certain techniques, such as mobile-phone measurement (Roche et al. 2014), do hold out promise for NPD – but it remains to be seen whether it can garner enough attention, as scientists are sentimental too.

Collins (2000:789) indicates that “empirical-discovery science… doggedly stick[s] to
a fixed level of abstraction,” which would appear to rule out Shwed and Bearman’s (2010:818) spiral patterns of scientific consensus. The distinction could be purely semantic: Can we call “scholars [moving] on to secondary questions” (Shwed & Bearman 2010:830) a rise in the level of abstraction? Not in the sense of Collins’ abstraction-reflexivity sequences (2000:787-800), but we’re left with some curiosities. The post-DSM-III era could be interpreted as “classificatory scholasticism” (796), wherein “[t]he number of various things becomes the topic of dispute” (797). As I suggested earlier, the official taxonomies serve as part of the material context in which practitioners find themselves. Diagnostic and research difficulties combined imply that NPD isn’t accurately counted – I personally say undercounted.

Epidemiology thus occupies a central role, helping to determine whether a disorder will be retained, but it is also simultaneously determined by the existent classificatory structure. Four respondents commented on these counts, and all were sceptical as to their worth. One CBT clinician (US-CP-3, 2.08.2013) compared depression and NPD as objects of study, concluding, “I don't know how we're going to get prevalence rates for something that many of the individuals don't consider a disorder.” Two more integrative practitioners (US-CP-4, DE-P-9) were divided as to the value of these numbers, but agreed that it was more important to find “what is the underlying motivational structure related to the person's problems in living” (US-CP-4, 3.05.2013). His German counterpart (DE-P-9, 12.03.2014) saw some worth in prevalence, but cautioned that they don’t tell us “what these people are missing and what causes the diseases.” Ignoring “prevalence data altogether, because it's based
on arbitrary cut-offs and a criterion set which is not valid” was a sentiment shared by this psychologist (US-CP-4, 3.05.2013) and a German psychiatrist (DE-P-5, 28.02.2014).

Two sources discussed possible fixes for these problems. A young practitioner (US-CP-2, 10.05.2013) suggested that concerns about epidemiology regarding PDs in DSM-5 were premature, saying, “It's a red herring, it's a pointless argument, why would we be talking about that until we have the dimensional issue resolved?” Another solution comes from Benjamin’s (2003:8) interpersonal therapy, which explains that: “Comorbidity of symptoms is not the same as comorbidity of disorders. The ‘problem’ of comorbidity disappears once you have viable theory to explain the symptoms.” Note that in both cases the proposed solution is theoretical: either one infuses theory into DSM directly by shifting to dimensionality (US-CP-2), or we undergird it with a complementary aetiological theory (Benjamin). The MMM, as well as the shared psychotherapeutic practices illustrated in Chapters Six and Seven, drew our attention to competition within the science of psychopathology. What we hear again is the echo of this struggle, which occurs at all levels, even that of classification. We ascend now to that arena.

(III) Classification, or: “There might be a consensus because they don’t need any theory for it”

When asked to describe his understanding of NPD, one practitioner (CH-P-1, 22.01.2014) commented on the complexity of NPD and of all psychiatric disorders. He set “the narcissistic disorder” apart as “particularly difficult because there’s no
unified (einheitliche) theory”. From here, he went on to contrast psychoanalytic and descriptive classificatory schemes:

“… I believe even inside of psychoanalysis there’s no unequivocal (eindeutige) narcissism-theory, and when you go to psychiatrists, for example, that don’t possess any theoretical foundation whatsoever, rather move ahead purely descriptively, phenomenologically with the [PDs], here you’ll find still less theory.”

He states that the present consensus is “the phenomenological-descriptive assessment (Diagnostik),” and sums up that, although this is a small patient group, “There might be a consensus because they don’t need any theory for it.”

Our psychiatric protagonist suggests the themes guiding this section: (a) that different classificatory schemes (and so different models) are squaring off, (b) good reasons exist to use the various systems, and (c) accordingly, each classification also has its flaws. Each of these matters will be addressed in turn with respect to (1) the non-DSM classificatory systems, (2) the DSM generally, and close with (3) the DSM-5, and Section III in particular, the alternative model for PDs. I argue that the DSM and ICD continue to succeed because they serve as linguae francae, yet continue to face competition for the reason they remain on top – the absence of explicit conceptualisation.

**(III.1) Categorising psychopathology without DSM, or: “So basically I’m kind of emotionally detached from that”**

When asked what diagnoses he gave insurance companies for narcissistic patients, a clinician (US-CP-1, 6.06.2013) explained that one typically had to use either DSM or ICD and clarified, “[s]o basically I’m kind of emotionally detached from that.”
clinical practice was to “use more of an object-relations, psychodynamic, Kernbergian model of personality pathology which isn’t directly translated into DSM.” There exist several alternate means of classifying PDs (and psychopathology more broadly) beyond the WHO and APA schemes. Some theoretical schools were further from these official classifications (e.g. TFP, ST) whereas others fit with them but offered an additional aetiological component (e.g. DBT, interpersonal). An ST practitioner confirmed this distinction between insurance forms and clinical practice, saying “we’re not very dependent on the DSM to guide our path” before continuing:

“So we’ll appreciate the criteria of DSM, but we’re much more concerned with the needs that have not been met. … So I think that conceptually, some might say, ‘Well the DSM is strong and conceptual,’ I would say, ‘[ST] is very strong in conceptualising, but we also have a conceptualisation that offers a treatment approach that matches our conceptualisation.’”

(US-LCSW-1, 16.09.2013)

Focusing thusly on unmet childhood needs is “what [ST] allows for in terms of dimension and spectrum approach”, in contrast to the “prototype in the DSM” (16.09.2013). Beyond practical advantages over the DSM, ST also “offers more than most models can provide” because “our model is evidence-based in terms of working with borderline patients and certain other patients” (10.07.2014). We see again the competitive elements in and legitimating function of science here.

Two more formalised diagnostic systems exist, both of which appear to be limited in their use to one context. In North America, there is the Psychodynamic Diagnostic Manual (PDM), and the German-speaking countries have Operationalised Psychodynamic Diagnosis (OPD-2, henceforth OPD). OPD is available in English translation (OPD 2008), but none of the North Americans mentioned it. The PDM
was independently (and briefly) mentioned only in an interview with a more classical psychoanalyst (US-PP-1). Of the two, the OPD is more comprehensive (including chapters on “focus selection and treatment planning” and change measurement), whereas the PDM is more concerned with “conceptual and research foundations”.

Part III of the PDM addresses these issues, and comprises roughly half the book: research alone (pp. 511-837) contributing 1/3 of the pages. Contrasted with the brief chapter in OPD on quality assurance (pp. 291-301, 407 pages total), we see a sharp difference between the two: in the German-speaking world, there is far less of a need to assert the scientific legitimacy of psychodynamic approaches.

Both are multiaxial: meaning they give clinicians several tools or means of examination. The PDM offers axes for personality patterns and disorders, mental functioning, and subjective experiences of symptom patterns. In contrast, “experience of illness and prerequisites for treatment”, interpersonal relations, conflict, structure, and mental and psychosomatic disorders round out the OPD. Some overlaps are obvious (structure/personality patterns, and subjective experience), but the manuals reflect a distinct conceptualisation. This variation, like that in emphasis on a research base, suggests national differences.

I did not consistently ask about the OPD for time reasons, but where I did, the results could be contradictory. One informant (DE-PP-11, 5.03.2014, field notes) described the manual as part of this compromise between psychoanalysis and science, and as “very useful for younger and inexperienced colleagues.” His countryman (DE-P-8,

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46 PDM includes a “Suitability and Indications for Psychoanalytic Psychotherapy” (pp. 403-430, 837 substantive pages) section.
6.05.2014) indicated that it was “a good extension” of assessment for research purposes, which jives with the notion the manual is somehow conciliatory. The functions it held for him were “When the assessor (Beurteiler), the OPD rater, has good clinical experience it’s helpful, and it’s naturally very helpful for research.” Beyond these opposites, there were also two practitioners (DE-P-5, DE-P-12) who used it as a sorting or visualisation tool. The more classically analytical one (DE-P-12, 17.02.2014) summarised cases for himself “in object-theoretical terms,” whereas with neurotics he tended to use the drive-axis. He concluded with this metaphor reminiscent of brain-scans:

“[T]he axial perspective makes a lot of sense to me because the psyche is a complex-dynamic system, and one has to cut it somehow, and then one knows, if I cut it thusly, then I see this, and when cut that way, I see this profile.”

Two Americans mentioned the PDM. It was a potentially useful tool, but not one they would employ. A psychoanalyst in private practice (US-PP-1, 23.05.2013) damned it with faint praise, for him the PDM’s content “about narcissism isn't really very developed, but at least it has more dimension to it (both laugh), and [is] more nuanced, for sure.” In the conversation where I raised the PDM as an alternative to DSM, the respondent (US-CP-9, 6.06.2013) explained that he “actually really like[s] it” but that it was “overly complex to use”. He then mused about the role of socialisation:

“I wonder if I’d actually really feel that if I grew up on the PDM as opposed to most of us have grown up on the DSM. It kind of reminds me of the Apple versus PC debate, it’s kind of whichever one you grew up with and are familiar with and you know how to use the systems.”

(US-CP-9)

Theory, in his opinion, limited the use of the PDM, but less so with the DSM,
because “at least those problems are consistent across groups.” Theoretically, the ICD would level things further still. Michael First describes the ICD and DSM as competitors (Greenberg 2013:110-111), which might explain the results below.

I limited my questions about the ICD to German-speaking Europe, and there only inquired (inconsistently, due to time constraints) about how they thought the DSM-5 might impact the ICD-11. The answers were evenly split between those who believed it should or would influence ICD-11 (A-P-1, CH-P-1, CH-P-2, DE-P-2, DE-P-3), and those who thought that it would not (A-P-2, DE-CP-1, DE-CP-3, DE-CP-6, DE-P-9). Several interesting asides emerged. Separating borderline and an emotional-instable type was seen as a structural problem in ICD-10, and this clinician expected the subtype to be dropped (CH-P-2, 20.02.2014). Others saw narcissism on the rise, and hoped that DSM-5’s retention of NPD would encourage the ICD to adopt it (A-P-1, DE-P-2). Most interesting was a psychiatrist (CH-P-1, 22.01.2014) who believed that there would be an influence, but that a divide would persist: “… and I also believe that the European and American tradition are nevertheless still somewhat different. So to speak, a unitary diagnostic scheme isn’t going to emerge in the next couple years.”

Of those who doubted, fascinating was a young German (DE-CP-3) who felt that ICD-11 “would surely change the PD section, and also surely include a dimensional survey of personality traits” (22.01.2014). The more common answers were uncertain predictions that the two would remain largely independent (DE-CP-1; DE-CP-6 used the metaphor of “tea-leaf reading” or Kaffeesatzlesen), or that Peter Tyrer
would set through a simplification of PD diagnosis to measure only severity, “a little bit like the ‘levels of personality functioning’” (quote A-P-2, 22.04.2014; cf. DE-P-9). A German (DE-P-9) was very enthusiastic about the ICD-11 simplifying things, saying, “it’s also important to have the same standards present in Third-World countries as in developed countries” (12.03.2014). His southerly colleague (A-P-2) left open the possibility that everything could remain unchanged except “then maybe this severity assessment would be added in on top.”

(III.2) Life in the day of DSM, or: “[I]t's already had two decades’ worth of criticisms levelled against it that I think are fairly supportable, but that's where we're at.”

In discussing the outcome for PDs in the DSM-5, one informant (US-CP-1, 6.06.2013) defended the choice to move the alternative model to Section III, but expressed the above reservations about it. DSM, at least with respect to PDs, is faulty but nevertheless functional in this telling. Many informants were of this basic opinion, and pointed out what they felt were major structural flaws in the document.

Several respondents (US-PP-1, DE-P-1, CH-P-1) referenced general problems with codified classifications. The American psychoanalyst offers a succinct summary of both the uses and how manualised diagnosis “fails” in his eyes:

“It's only used to satisfy certain needs: either insurance companies or researchers who need to have categories… often you don't get to find out about the real person for quite a while, until some of the initial defences are reckoned with and there's a greater sense of trust in the relationship.” (US-PP-1, 23.05.2013)

For a CBT practitioner (DE-P-1), the problem was specifically the assessment of
vulnerable narcissism. He felt that, “principally you cannot at all capture these patients in a, let’s say, diagnostic manual or a diagnosis” (11.02.2014). Somewhere in between these two stood a psychodynamic psychiatrist, who like others (e.g. DE-P-2, US-CP-1), felt that “only a specific type of narcissism is portrayed in the DSM and ICD systems”, which was “a bit like a caricature of narcissism” (CH-P-1, 22.01.2014). He described this depiction as “like the tip of an iceberg” behind which one could “assume” (vermuten) a variety of other disorders: “[w]ithout being allowed to classify them as narcissistic disorder under the current classification system.”

The same informant (CH-P-1) explained that manuals could remove disorders but that this did not erase them from existence: “So, for example, I personally still use the concept of neurosis but in principle neurosis has vanished. But it exists of course.” A contemporary example would be the multiaxial system’s removal from DSM-5, which one clinician felt was a mistake “because it forced clinicians to look at various factors” (US-CP-3, 2.08.2013). This position was uncommon; most practitioners (e.g. CA-CSW-1) felt this was a step forward, an end to the ghettoization of PDs. Personally, I found this celebration odd as it seemed to be founded on a false assumption that the DSM axes were ordinal, and thus PDs were somehow subjugated. Moving PDs from Axis II into a combined “Diagnostic Criteria and Codes” section might actually make them sink further into obscurity. While it is true that PDs have problems (e.g. that they’re not seen as illnesses), the change here is cosmetic. I predict little change in overall diagnosis rates for PDs.

Criteria were taken to be problematic, both generally and for NPD. One clinician
(US-CP-3, 2.08.2013) used the example of “pervasive feelings of emptiness” and his own hunger to underscore that “many of the criteria are unclear.” Rising rates of ADHD, Asperger’s, borderline, or bipolar were attributed to the “very ‘weak’ and very diffuse” criteria used in DSM (CH-P-1, 22.01.2014). The notion of “some magic line” between pathology and normality (US-SPP-1, 26.05.2014) was roundly rejected (e.g. DE-CP-2, DE-PP-1), or at least it was indicated that this division was arbitrary (e.g. US-CP-4). A psychoanalyst indicated that because of the difference between research and clinical work, the standards could become even more lax:

“[M]ost clinicians don’t do that, and don’t go back and look it up every time they think about it, and if they don’t remember the criteria, they don’t care, they just kind of use the label the way they use the label.” (US-PP-3, 9.05.2013)

A patient might meet two criteria for NPD, for example, “and you say they’re narcissistic, because the two are pretty pronounced” (US-PP-3). The validity of the NPD criteria was also questioned by some individuals (e.g. DE-P-2, US-CP-1, US-CP-4). One clinician went so far as to say, “a great many of the empirically valid criteria for disorders don’t even appear in DSM” (DE-CP-6, 25.02.2014). There is some agreement then, that “the DSM isn’t on the cutting edge empirically (nicht auf dem neusten empirischen Stand)” (DE-CP-6, 25.02.2014) across theoretical traditions (compare this COP practitioner to a TFP/interpersonal clinician, US-CP-2, above) and regardless of differences in diagnostic threshold (cf. DE-CP-1 and DE-CP-7). The lack of context for DSM criteria (see e.g. Horwitz & Wakefield 2007, esp. 113-119) was discussed against the backdrop of when a practitioner wouldn’t give an NPD diagnosis. He (CH-P-1) stressed that you could meet criteria while it was nevertheless a “situational, crisis-bound difficulty,” or meet few criteria and still have a “pronounced internal disturbance (Problematik) or pathology” (22.01.2014).
Related to both specific criteria and the structure of the DSM is dimensionality. Virtually all points on the theoretical spectrum agreed that narcissism was best conceived of as a continuum (e.g. CA-P-1; CA-CSW-1; DE-CP-1; DE-CP-2, 12.02.2014; DE-P-2; US-CP-2; US-CP-7). The listed informants varied in their ‘scientism,’ as measured by their use of validated scales and/or active engagement with the empirical literature. A range of reasons underlay dimensional convictions: theory (US-P-3), empiricism in a journal science sense (DE-CP-1), its match with clinical experience (US-CP-2), or some mixture of these factors. Dimensionality could simply be good to think with, a meaningful way of structuring one’s understanding of personality and its pathologies. While I suspect this is at play in all these answers, I have no proof either way. A practitioner (US-CP-7, 26.06.2013) who “advocate[d] moving toward a more symptom-dimensional based model” felt “labels are fine, cos they're useful for communication, but they have to be the right labels, and they have to mean the right things.” In other words, categories are in some sense a necessary shorthand for purposes of communication and funding (CA-CSW-1, 6.09.2013).

The issue of traits was a related and contentious issue: “Even though they said that [DSM-III PDs] were defined in terms of traits, they really weren’t defined in terms of traits, and it seemed to me that they should be defined in terms of traits” (US-CP-7, 26.06.2013). A summary I think almost all of my informants could agree with is that “humans, like nature overall, don’t always do us the favour and embody the categories that somebody has established” (DE-P-10, 21.03.2014; cf. Greenberg
2013:118-119 on DSM as convenient fiction). He said categorical description has a “subordinate role” in the clinic, because their job is “to describe an individual”.

Familiar to the pitchfork and torch-wielding anti-psychiatrist is the notion that DSM overpathologises. Unsurprisingly, this ‘critique’ offered by sociologists is redundant: from CBT (DE-CP-7) to ST (DE-PP-2) to the range of psychodynamic practitioners (A-P-1, DE-CP-5, DE-P-7), there was agreement on this point. An NPD-sceptic (DE-CP-7, 21.02.2014) pointed out that 20-30% of the population would meet criteria for NPD as described in Section III. In North America, a psychiatrist (CA-P-1) voiced concerns over diagnostic expansion, saying, “I’m personally inclined to stick with the grandiose type… If they don’t show it, how narcissistic can they be really?” (21.08.2013).

Similarly incredulous, but speaking of psychopathology more globally, a classical analyst (DE-CP-5, 4.03.2014) reported that by epidemiological counts, “approximately 25% of the total population here in a country like Germany must be really, severely psychopathological.” At the intersection of overpathologising and dimensionality was the same analyst’s answer to a question about DSM-5 measuring levels of PD severity:

“Somehow one has to turn that around, that’s what matters, that one has to like something about one’s patient, otherwise it doesn’t work. I like to say that one depresses one’s patient by diagnosing (niederdiagnostiziert), would diagnose down (runterdiagnostiziert). When one takes this tendency seriously, so to speak, what’s the effect? One sees only pathology, pathology, pathology in one’s patients and then they can’t get better.” (DE-CP-5, 4.03.2014)

We see here a practical result of the psychodynamic stance “that we all fall
somewhere along this continuum, and that we may actually move and fluctuate and be at different points along that continuum at different points in our life” (CA-CSW-1, 6.09.2013).

DSM is often accused of being built as biological-reductionist, though “[DSM-III] was designed to be theory-neutral and compatible with social and psychological, as well as biological, causes of symptoms” (Horwitz & Wakefield 2007:165; cf. Young 1995:115 on PTSD in DSM-III and III-R). As one psychiatrist informed us, this neutrality is a key component of its continuing success: “There might be a consensus because they don’t need any theory for it” (CH-P-1, 22.01.2014). Indeed, one biologically-oriented psychiatrist I spoke with explained that DSM NPD couldn’t be translated into biologic terms:

“[S]ince [NPD] is defined in very different terms than biologic vulnerabilities, for example talk about biologic vulnerabilities to affective instability or to aggression, as by-products of some of the vulnerabilities some people may get more narcissistic personality structure, but I don’t think it’s defined in a way that lends itself to a uniform and multifactorial biologic underpinning. That’s not to say it’s not there, in its own place, but the disorder isn’t defined in such a way to explore those relationships in patients who might have the disorder.”

(US-P-2, 11.07.2014)

When I discussed the NIMH’s RDoC with a younger clinician (US-CP-9, 6.06.2013), he stressed that “you're never going to do that, because insurance companies don’t know how to bill for biological sensitivities to things in a dimensional continuum.”

He began with the multiple constituencies problem, and went on to elaborate on this:

“So I think that the fundamental problem – and really it goes beyond PDs, I think it goes to things like depression and things like anxiety – is I think the researchers want to focus on dimensions, they want to link things to neural substrates and biological

He did say, “If we could scrap the system and do it completely over again using just biological mechanisms, then that does represent a good path moving forward” (6.06.2013).
mechanisms, which I think is a great idea once they can figure out how to do that, but I don’t think they’ve figured out how to do it yet. But the people who use it to diagnose, who are kind of the frontline people, they need to have a simple way to do it. And I don’t think that those two pieces are compatible. But they try to do the best they can in the DSM, and I think the DSM is relatively effective at bridging that gap.” (6.06.2013)

Greenberg (2013) mentions a related problem of the RDoC will eventually needing to make some determinations if its results are to be clinically useful:

“[F]igure out where fear of loss is and where it leaves off and attachment/separation fear sets in, and how much of each is pathological and when and whether to say the measured symptoms add up to an illness.” (344-345)

But essentially these problems plague all of science and medicine. Where does the wolf end and the dog begin? And on the question of pathology, an ethnographic example: Germans will see their GP and take two weeks off for a cold, while Americans will work through it.

Just a few pages earlier, however, Greenberg gives the example of melancholia (2013:335-338), a discrete mood disorder with a physical test: the dexamethasone suppression test (336). He is right to pan the DSM mood disorders Work Group for not including it, but this exclusion may argue against his earlier point. While he didn’t mention the dexamethasone suppression test, one German psychiatrist (DE-P-1, 11.02.2014) felt that biological tests were necessary: “As long as [psychiatry] doesn’t have [biological bases for assessment], every system will carry a more or less essential problem” of how to separate the normal and the pathological. The consensus seems to be that “the categories that DSM uses, they're phenotypic, and there's nothing to say that's the way that the pathological processes are actually

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48 My brother Tobias suggested this metaphor.
organised” (US-CP-7, 26.06.2013). DSM, then, stands on the horns of a dilemma, where categories are necessary for the everyday efforts, but don’t reflect the actual state of our present understanding of psychopathology.

(III.3) DSM-5, or: “It’s a curse and it’s a blessing”

When I asked a German psychiatrist (DE-P-1, 11.02.2014) how he felt about DSM-5, he explained that he’d tell me what he told his students, namely: “It’s a curse and it’s a blessing, if it were just a bit more curse than blessing, then it would have been dismissed long ago. But it’s both.” He suggests here the bridging, compromise, or *lingua franca* role that DSM has and continues to serve among its many constituencies. All these metaphors suggest politics, which was far from a taboo subject.

Many informants (e.g. US-CP-2, US-CP-3, US-CP-7, US-P-3, US-SPP-1) reminded me that DSM is both a scientific and a political document. The procedure used to generate the manual was seen by some as limiting. For an assessment specialist (US-CCP-7, 26.06.2013), it wasn’t that NPD didn’t exist but that “you don’t need a whole *category* infrastructure” to describe the disorder. Similarly, retention of a categorical view was seen by some as a failure of process:

“And, to have, thirty-three years later virtually nothing change, it just astonishes me. Like, how can that be? Either, we learned nothing, or something else is wrong with the process such that it prevents it from actually developing and actually changing. So for me it was really eye-opening to learn just how little that manual is based on science, and how little actual deep thinking goes into it. And that can be (laughing to himself) pretty *demoralising.*”

(US-CP-2, 10.05.2013)

He went as far as to say “the DSM and the American Psychiatric Association can’t be
trusted to be the custodians of psychopathology.” Some cast the decision to retain NPD as scientific, however, suggesting that “the people who wanted to remove it failed to recognise that about 50% of the literature that was out there on it that just wasn’t called NPD” (US-CP-9, 6.06.2013).

In discussing the relationship between research into, and the assessment and treatment of NPD, a researcher (US-SPP-1, 26.05.2014) defined vulnerability’s role in pathological narcissism as a flashpoint for conflict. He repeatedly described writing the DSM as “sausage-making,” and explained that “they made the same mistake twice” in DSM-IV and 5 where “the traits capture more grandiosity, and then the description captures more vulnerability” (26.05.2014). Contrary to his expectations, however, at least one clinician (US-CP-9) agreed with him that “vulnerability would be a specifier” (US-SPP-1, 26.05.2014) in order to improve the model. I asked the research psychologist why he felt the way DSM-5 dealt with vulnerability was “unwieldly,” leading him to muse on evidence:

“It has a sentence that says, ‘The self can be inflated, deflated, or vacillate between inflation and deflation.’ What the hell does that mean? (CFD laughs.) It means nothing. And there’s no evidence for vacillating self-systems in narcissism at all. I’ve never seen any evidence for the radical vacillation.”

We are thrust again into the issues of what is evidence, what qualifies as empirical, and how do we adjudicate between competing models? Despite disagreements as to the appropriate content, a wide range of respondents felt that there was something inherently wrong with the DSM process.

Discussions of the DSM-5 often prompted reflection on science, and the role of self-
interest therein. Two American clinicians with opposite opinions on the appropriateness of placing the alternative model for PDs in Section III provide varied accounts on the role of self-interest. One (US-CP-6) saw the leadership’s desire to innovate as overwhelming the evidence:

“I think that Kupfer and Regier, who are in charge of DSM-5 in general, are pushing for paradigm shifts that probably aren't backed by the data. Or may not be backed by necessity. I'm a little bit cynical about the motivation behind it. My experience of people when they're in charge of big things like that, they want to have their mark.”  

(7.06.2013)

Even here, however, we cannot outrun conceptualisation. Looking at the Work Group on Personality and PDs, “a sort of junior person” (US-CP-4, 3.05.2013) opined: “I think it's been petty, and it hasn't been all that evidence-based, and it's mostly been about people with strong affective connections to things that they said in the literature, sort of trying to mark up their own territory.” What we see on both levels is competition – in individuals (Kupfer, Regier), across groups (psychoanalysts, descriptive psychiatrists, and trait psychology, according to US-CP-4), and between concepts. There is some suggestion of this even in Kupfer and Regier, where the first respondent (US-CP-6) went on, “I think some of it is actually the distorted belief about what constitutes psychopathology.” His comment is ambiguous, however – he could just as easily be discussing members of the Work Group.

The informant who introduced us to self-interest in the DSM-5 went on to frame the ultimate result for PDs as the correct one. He and one other senior clinician (US-CP-1, 6.06.2013) were exceptional in saying that the conservativism shown was scientifically justified, “[a]s long as we do the requisite research”: “I think actually
science worked, that it should work in the end. We're going to study it better and we're sticking with what we have for now because there isn't compelling evidence to necessarily change it quite yet” (US-CP-6, 7.06.2013). When I was conducting my research, I was first swayed by Mark Zimmerman (2013) who pointed out that there was no compelling scientific rationale for DSM-5. The younger informants then carried me over to thinking that this was a travesty. I now think that both were right: not to be wishy-washy, because there was no real reason for the DSM-5, but if they were going to do it, they could have at least reworked the PDs.

The new model itself was panned as not “exactly scientific. So we've replaced the proposed not-too-scientific model with the older, non-scientific model. It's certainly not a step forward” (CA-CSW-1, 6.09.2013). Here a psychodynamic practitioner agrees with CBT (DE-CP-1, DE-CP-3) and DBT (US-CP-10) therapists about the lack of evidence for the new model. On this front, both those who approve of and disagree with the banishment are united. I do agree that if the Work Group had the option to adopt an existing dimensional model of personality, that would have been better, scientifically speaking. There are, however, several million reasons why the DSM launched an unproven warrior into the fray:

“'We knew we couldn’t incorporate anybody’s model in toto,’ [Andrew Skodol, chair of DSM-5’s PD Work Group] told me, 'because the APA wasn’t going to pay royalties’ to any copyright holder.” (Greenberg 2013:269-270)

Self-interest strikes again, triumphing over any scientific scrutiny.

Younger clinicians (e.g. DE-CP-3, US-CP-2, US-CP-4) tended to see more positive aspects in the alternative model. Human beings’ cognitive constitution was cited by
one senior clinician (DE-P-1) as a reason why the alternative model is so impractical:

“Seen scientifically, it’s interesting, but it’s unusable in practice because humans don’t think scientifically. Humans think in images…. And insofar people always need some handy formulas and images, and that is to my knowledge more a scientific model, so that it would be practically unusable.”
(11.02.2014; cf. Luhrmann 2000:40-44)

The unsuitability of the alternative model for clinical practice was agreed upon across the theoretical spectrum, from dynamic (A-P-2) to integrative (DE-P-9) to CBT (DE-P-1). Even the most ‘scientistic’ psychiatrist I spoke with (CA-P-1) felt “it would’ve hurt all of us who treat [PDs] and the patients with [PDs] because there’s already a tremendous resistance to diagnosing [PDs]” (21.08.2013). One practitioner (US-CP-5) did enthusiastically endorse the alternative model, not as a clinical tool but as means of “open[ing] up the door for continuing research” (19.05.2014).

Somewhat similar was a senior psychoanalyst who suggested, ‘A successful system of psychiatric nosology, however, needs both [categorical and dimensional] criteria integrated. DSM-5 moves somewhat in this direction’ (US-P-1, 25.06.2013, fieldnotes).

A proponent of the new model, who hoped “in the next update this categorical assessment gets sent into Nirvana,” felt that the “thresholds for giving [NPD] are much too soft” (DE-CP-7, 21.02.2014; cf. DE-CP-1 for similar concerns about diagnostic expansion under the alternative model). Both this sceptic (DE-CP-7) and an unusually DSM-oriented psychoanalytic psychiatrist (CH-P-2, 20.02.2014) felt that the alternative model could be reworked into something useful. Another outlier (if I may presume to mathematical metaphors) was a senior German psychoanalyst. When I explained Section III to him, he said, ‘I’ve already got a problem with this
divide [between self and interpersonal functioning]. Where’s the border? The skin?’ and went on to speak about identification and how our thought patterns (Denkweisen) are shaped by our social ties (DE-P-11, 5.03.2014, fieldnotes).

Generally, approval was hedged or moderated in some way. Psychodynamic practitioners (e.g. US-CP-11) and CBT clinicians (e.g, DE-CP-3) agreed that it was good that dimensionality and levels of functioning were underscored, but felt that the implementation was imperfect. Several clinicians who used TFP (e.g. A-P-1, CH-P-1, US-P-1) and even some who didn’t (US-CP-4) pointed out that the idea of levels of personality functioning owed a lot to Kernberg, “unfortunately without naming him” (US-P-1, 28.05.2014). Some felt that the alternative model contained “an analytic, not psychological, theory” (DE-CP-6, 25.02.2014): in other words, ‘it’s the implementation, stupid’ yet again. I asked him what a psychological theory would look like, and he said, “… for example, schema theory. Conceptualising self-pathology under schema aspects” (DE-CP-6). Using Beck’s schema model would have equally valid in my opinion, though not necessarily on scientific grounds. A purely rational approach would’ve generated evidence, and compared the “analytic” and schema models on outcome and fit with data. The objection seems to stem from an unspoken belief that psychoanalytic=unscientific, rather than empirical reasons. Competition clambers out again.

If science was one means of legitimation, it ought to be more powerful still when combined with traditional or historical validation. Path dependency emerged in two distinct ways: as it related to training (the intersection of biographical and
institutional histories) and to the history of ideas. When I asked a then-recent PhD about the relationship between science, the DSM, and dimensionality, he went into a meditation on the role of socialisation in psychiatric sight:

“And what I don't get is that you have people that will defend the categories versus the dimensions based on, ‘I'm a clinician and this is what I see.’ Really? … I just don't understand this argument while clinicians believe in these types and that's the way they believe the world is structured, it's like, Oh, really? Or is it just what they've been told they need to use, and so they use it, and that's the way they start to think about the world.”

(US-CP-2, 10.05.2013)

His argument, omitted by the ellipses above, focused on the fact that excepting Kraeplin and the Feighner Criteria, clinicians have thought dimensionally. My read is that he is arguing that psychiatry is following the wrong precedent, and that individuals raised on categorical distinction accept it as fact. History is here both legitimating and lamentable in turn.

Traits and dimensionality are a big issue in the field of PDs, although all my informants in some way endorsed the use of continua. In discussing Criterion B of the alternative model, one informant highlighted the historical contingency of assessing personality through traits:

“Now with respect to the traits, I think the fact that people think about traits as diagnostic of PD is a historical artefact, nothing natural about that. In fact, if you look at the relationship between traits and PDs, they're weaker than the relationships between traits and Axis I disorders, meta-analytically. So there's nothing natural about thinking about personality traits as markers of PD. It's just that they both have this word personality, which for historical, accidental reasons, modifies both terms.”

(US-CP-4, 3.05.2013)

For him, the value of the traits would be more “as a way of reorganising the entire taxonomy.” He went on to argue for “a possible marriage between trait thinking and
psychoanalytic thinking”:

“...[T]he good thing about psychoanalytic thinking is that it's deep and inferential and captures dynamic processes, the bad thing is that a lot of that stuff isn't all that measurable. And so what trait psychology provides is a structure of individual differences which is measurable. And in fact, those dynamics that I think analysts are concerned with can be conceptualised using traits, right? Like, one dynamic is negative emotion, and another dynamic is attachment versus distance. If you think of the traits as providing the structure, the traits don't have to be static concepts, those things can change over time and have dynamic relationships with one another.”

He saw Section III as “a good start in that direction,” but felt that “politics basically just got in the way and I don't [think] people are that interested in trying to understand another person's perspective” (3.05.2013). In brief, competition and historical contingencies prevent the fruitful advance of personality science.

(IV) Discussion

The science of pathological narcissism is messy, caught within an overcrowded attention-space wherein competition doesn't spur eventual consensus. Our woes are technological and sociological in equal measure: Attempts exist to thin the herd by rendering psychoanalytic approaches unscientific (Gieryn’s expulsion), and to seek rewards through generating new instruments for assessment.

I encountered the curious finding that psychoanalysis stood in a different sort of relation to science than other theoretical traditions. Depending on the informant, it could be seen as a different type of science, compatible with science, or forced by circumstance into a compromise with science as typically understood. Most fruitful here was the notion of “the empirical-hermeneutic uncertainty principle” (DE-P-12,
17.02.2014) or “quantum psychiatry” (US-CP-2, 10.05.2013). What these reflect, respectively, is the trade-offs researchers make: particularism and generality in the first case, and between prevalence and course in the second.

Overall, the problems related to science can be summarised in three basic tensions: (a) clinical vs. scientific logic, (b) clinical vs. scientific knowledge, and (c) clinical knowledge vs. clinical experience. These strains were explored through the examples of the NPI, and the DSM and its competitors. We see again the basic point that measures are – and must be – theory-laden, but that if one disagrees with the conceptualisation (or its concomitant assumptions), the measure will be unacceptable.

Fractionation, not synthesis, seems to be the dominant form of creativity in the NPD attention-space. Measures thus arise, largely in opposition to the NPI. While Pincus’ PNI is in many ways synthetic, it further expands the field of potential research technologies. A related problem is how we divide narcissism: broad agreement exists that it is continuous, not categorical, but there exist multiple candidates for this continuum. In both cases, we’re left with no ultimate arbiter and ineffectual competition. Peer review only seems to accredit those conceptualisations to which a practitioner is already favourably predisposed. These factors may help explain why validity was sometimes invoked as gatekeeper between clinical and scientific knowledge (DE-P-6). Others saw these knowledges as “overlapping” (US-CP-6) or as existing on a continuum (A-P-2), with reproducibility being the yardstick.
Schools stood in different relations to the official classification systems. I argued that DSM and ICD are in a paradoxical position: being largely descriptive enables them to remain dominant, but creates a niche for explicitly theory-driven competitors. Categories are necessary for the everyday efforts, but don’t reflect the actual state of our present understanding of psychopathology. Self-interest emerged in discussions of DSM-5, both overall and within the Personality and PDs Work Group. Approval of the alternative model was generally hedged, which was at best seen as a foot-in-the-door. Science can be called on to legitimate or attack any position.

Competition appears to block fruitful syntheses, as with trait and psychodynamic approaches (US-CP-4). In general, two poxes plague pathological narcissism: first, attention-space is overcrowded. Practitioners can respond by creating idiosyncratic amalgamations or focusing on their own school. Looming larger is the problem of “genealogies of research technologies” (Collins 2000:538). Self-interest leads to fractionation, which worsens both issues. Withdrawal into a theoretical enclave generates solidarity for the individual practitioner and eases many difficulties of everyday clinical or research work. Pathological narcissism is, in my estimation, caught in a negative feedback loop. Both intellectual and more material technologies are stunted by a field spread too thin. Theory is no panacea, but one of several necessary components for a scientific field to advance. If we continue to regard it as an overreach or somehow superfluous, both patients and psychopathology as a science will suffer for our sins.
Chapter 9: Cornered by Conceptualisation?

“Different intellectual traditions …will remain separated as long as those in each tradition restrict their sympathetic attention to works of their own school and view others with contempt or hostility.” (Shibutani 1955:566)

“[CFD: Why do you think there’s been this shift and how do we escape this ritualism, as you’ve described it?]

I say reality’s my best friend. By confronting reality. I believe in reality, and I think it’s simple: we need to work harder to use the standards of natural science. I ask graduate students, ‘What is the difference between theory and data?’ They’re very simplistic. They’ll say, ‘Theory’s not true, it’s speculative and data is true.’ We have to go beyond that.” (US-CP-8, 20.8.2013)

Pride is a very human failing. And ultimately, no one of us is immune to an overdose and its ill effects. Conceptualisation can therefore be tricky, because it provides a steady stream of the two substances humans are most addicted to: pride and solidarity. I would be a fool, however, to say that this somehow renders models unscientific. What theory provides is a framework by which to sort information, a guide for relating to the patient and other practitioners, and how and when to intervene, including advice on when the time has come to terminate treatment.

Theory thus extends the clinician not merely a community, but gives the practitioner a means for welcoming the patient therein. It helps to set the rules which ritually –
and thus also ethically – set psychotherapy apart from everyday life. While I have stridently suggested that labelling theory needs to be amended, I may have been too harsh and perhaps even made something of a Scheff-strawman. Examining “such changes over time as are basic and common to the members of a social category” (Goffman 1961:127) leads to the conclusion that every concept has a career. Put glibly, models are not static: A growing number of practitioners incorporate a more refined approach to labelling in order to comprehend – and hopefully contain – the ill effects of psychiatric diagnosis. This application and extension isn’t limited to certain professions (e.g. clinical psychologists like Lucy Johnstone, Peter Kinderman, and John Read) but runs the gamut of mental health professionals⁴⁹. Even here we observe that concepts are dynamic and fluid, helping to shape a system these very models were moulded by.

As Leeuwenhoek and Fleck (1979) teach us, no basic or applied science – irrespective of its hardness – is immune to competition, conceptualisation, and self-interest. I have argued that an Ansatz shapes relational work at every stage (Zelizer 2012:146): generating boundaries (between traditions, influencing how the patient/practitioner relationship and clinic/lab divide are understood), shared understandings within the boundary, and norms and media for appropriate cross-boundary interactions. Amalgamation, segregation, or translation are generic mechanisms which are then applied in light of (individual and/or institutional) history, how crowded the attention-space is, and interactions within thought communities. A

⁴⁹ See the Critical Psychiatry Network (http://www.criticalpsychiatry.co.uk/) website and some Mad in America authors (https://www.madinamerica.com/writers-page/) for examples of how broad this coalition is.
concept’s career is therefore ceremonial, ethical, emotional, and logical: Not one or the other, but swinging together like a jazz band, the limelight limberly leaping between them.

To say that the ritual and the rational can be held apart is therefore folly, but contending that no difference exists between nature and culture is farcical. We are all imperfect. Solidarity relies in equal measure upon identification and differentiation (Davies 2009:228-232; cf. Coser 1964), and consensus and conflict always exist side by side. While the aim of rationalisation has been to separate the ritual and the rational, to some extent it will always fail in this regard. I don’t despair for science, however, because we can only ever approximate it, and the technological must always bear in mind the relational. If we can hold onto our humanity, flawed as it may be, while also coming to better understand the world and our selves – then whatever impediment our emotionality is to science is a worthy sacrifice.

The minor of differences of narcissism are founded upon the narcissism of minor differences, it is true. Narcissists are thus twice damned, once by their past and again by us. I don’t decree, “Psychotherapist, heal thyself!” but instead say, let us find better ways of knowing, and thus of healing. Our overdose is only fatal if we don’t counteract hubris with humility, and so save one another.
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