**Title: Standard Model for Cluster B Personality Disorders**

**Author: Sam Vaknin, Ph.D.,** Visiting Professor of Psychology, Southern Federal University, Rostov-on-Don, Russia and Professor of Finance and Psychology in SIAS-CIAPS (Centre for International Advanced and Professional Studies).

**Abstract**

I discuss my new concept of covert borderline and the bridge between overt and covert cluster B states via collapse and narcissistic mortification. It is a standard model of personality disorders, akin to the standard model in particle physics: it unifies all personality disorders into a single clinical entity and predicts new diagnoses.

**Event: Lecture at the Department of Psychiatry, McGill University, Canada, January 22, 2021**

**Lecture Notes**

1. **STANDARD MODEL of CLUSTER B PDs**

The DSM suffers from issues of rampant comorbidity and heterogeneity (the polythetic problem), and multiplication of clinical entities (non-parsimony, contravening Occam’s razor). These clear indications that we are on the wrong path.

Physics and chemistry were in this place before.

The Standard Model in physics allows us to predict the existence and qualities of particles.

The periodic table in chemistry has the same function.

**THREE by TWO and TWO BY THREE MODEL**

Organizing and hermeneutic principles of cluster B (erratic, dramatic) personality disorders:

**Three states** (overt, collapsed, and covert),

**Two emotions**/affects (Mastersonian shame, Kleinian envy),

**two reality principles** which impair reality testing (confusing internal with external objects or external with internal objects),

**two traumatic bridging/transitional processes** (collapse, mortification)

**Three cognitive-perceptual deficits/defense mechanisms/traits** (dissociation, grandiosity and paranoia)

This model allows us to predict the existence of a covert psychopath (identical with the secondary factor-2 psychopath subtype common among Borderline women), covert histrionic, and a covert borderline (to be discussed later). (Borderline Personality Disorder with Psychopathic Traits: A Critical Review Lopez-Villatoro JM, Palomares N, Díaz-Marsá M and Carrasco JL).

All mental health issues arise from confusing external and internal objects (examples: psychosis, narcissism).  
  
I have been suggesting since 1995 that there is a single clinical post-traumatic entity Personality Disorder with overlays which are self-states (narcissistic, antisocial, borderline, histrionic).

As Judith Herman observes CPTSD complex trauma victims indistinguishable from BPD (dysregulation, lability) and develop situational narcissism (Robert Millman), dysempathy, and secondary psychopathy. (“The Tendency for Interpersonal Victimhood: The Personality Construct and its Consequences” (Gabay, Hameiri et al, 2020) Personality and Individual Differences, Volume 165, 15 October 2020).

The dimensional approach in DSM 5 (Alternative model) and the ICD 11 are moving in this direction.

Each overlay has 3 states: overt, collapsed, covert.

Given stressors that lead to mortification (“hitting rock bottom”) patients transition between these overlays and states (which explains the optics of comorbidity). There is no type or trait constancy.

The transition between the states and the overlays is a reaction to stressful gaps (intrusion of internal reality or intrusion of external reality or failure, which undermine fantasy/narrative), collapse, and narcissistic mortification.

The transition from overt to covert and back via collapse and mortification are attempts to revert locus of control.

Covert states are unstable and degenerate or evolve to overt states (sometimes with the help of substance use), because …

Covert states are not self-efficacious. They fail to secure:

Narcissistic Supply (NPD)

Goals (AsPD)

Sex Partners (HPD)

Relationships/intimacy/object permanence or constancy (BPD)

1. **PDs, TRAUMA, DISSOCIATED SELF-STATES**

Dissociation: discontinuities in the “normal integration of consciousness, memory, identity, emotion, perception, body representation, motor control, and behavior” (American Psychiatric Association, 2013)

It is an explicit adoption of the trauma model of dissociation (see Dalenberg et al., 2012; Gleaves, 1996, criticism Giesbrecht et al., 2008).

Sociocognitive Model holds that social, cultural, and cognitive variables combine to foster a credible personal narrative of multiple selves.

Source of confusion is:

Trauma can be external or internal (a reaction to chronic or mental illness, for example).

Philip Bromberg: Personality disorders are narratives intended to paper over identity diffusion and discontinuities induced by post-traumatic dissociation.

Consider the constructs of narcissism and psychopathy.

**Pathological Narcissism** may be a universal reaction to the internally-generated trauma caused by other mental health issues, by mental illness in general.

Narcissistic defenses mask the core issues, allocate scarce mental resources, and protect the individual from decompensation, acting out, and, ultimately, psychosis.

BPD and NPD are post-traumatic conditions with multiple self-states.

**Psychopathy** as self-state, protective ego resource in DID, BPD (secondary), NPD, HPD, PPD.  
  
Decompensation owing to intolerable anticipated or actual stress or trauma (CPTSD/PTSD): grandiose and fantasy defenses crumble and lead to acting out or even to suicide.  
  
Emergence of a psychopathic protective self-state (same in DID).  
  
But protect from what?  
  
NPD: injury, mortification (hypervigilance) leads to contact with trauma traces, access to repressed emotions - NPD becomes BPD (Grotstein: BPD failed narcissist).  
  
PPD: threat (paranoid ideation, persecutory delusions)  
  
BPD: abandonment, rejection  
  
HPD: rejection, injury

When the protective self is overactive or is the only self-state/resource, we get hybrids types (comorbidity) like the malignant narcissist (Fromm, Herbert Rosenfeld, Kernberg), Millon's Unprincipled Narcissist, Disingenuous Histrionic, and Impulsive Borderline.

Back to narcissism.

Narcissism is a core feature of the personality: primary narcissism in infancy is critical to the formation of the self, healthy narcissism helps us to regulate our sense of self-worth and guarantees self-efficacy.

Like cancer, narcissism can become malignant and be triggered in its sick form by any trauma and in any mental illness. It acquires the features of the underlying primary core mental health issue and serves as an overlay (veneer, coat of paint). It is a misleading facade presented to the world - and to diagnosticians.

Pathological narcissism is a narrative intended to disguise discontinuities in memory and identity (post-traumatic dissociation). One of the main functions of the shared fantasy is to project to the world a façade of normalcy and equally, to self-delude the narcissist that he is all but normal. It is a form of virtue signalling. But it has another role: to glamorize dysfunction and elevate it to the level of an ideology of superiority.

Children with impaired and incompetent disorganized personality or with a self-defeating, ornery temperament are shunned, ridiculed, and bullied. To compensate for these painful experiences, they sometimes recast their freakish idiosyncracies as choices, thus restoring an internal locus of control.

Thus, the schizoid or autist boasts grandiosely about his self-sufficiency, emotional imperturbability, resilience, razor-sharp focus, extreme IQ, social selectivity, and asexuality. These render him superhuman in his eyes.

Similarly, the sadist brags about his altruism, rationality, invulnerability, perspicacity, and imperviousness to weakness and to pain.

Drill down to find that compensatory narcissism is merely the fantasy aggrandizing veneer superimposed on other mental health disorders and their harrowing lifelong costs.

The only kind of relationship the narcissist has is with his absence and impoverished, inner emptiness, via grandiosity or envy.

1. **INTERNAL and EXTERNAL OBJECTS**

Poor boundaries (disrupted separation-individuation), ego-dystonic introjects/imagoes (inner critic/sadistic superego), dysfunctional constructs, anxiolytic inner representations (merged, fused, and easily controlled and manipulated) create a problem of attribution: many internal objects used to be external. Confusion leads to narcissism or to psychosis.

The psychotic mistakes internal objects (such as introjects and constructs) for external ones (via hyperreflexion), the narcissistic patient mistakes external objects for internal ones (snapshotting as part of co-idealization, extensions), the schizoid has no access to objects, or impoverishment of object (“emptiness”), the borderline is interim condition between narcissistic and psychotic (Kernberg).

The Typology of inner objects corresponds to the Jungian archetypes:  
  
The Self as the authentic voice (in attribution)  
  
Jung: "The shadow, the wise old man, the child, the mother ... and her counterpart, the maiden, and lastly the anima in man and the animus in woman".  
  
Persecutor  
Sage  
Infant  
Mother  
Gender  
Sex (vulnerability, life)  
Death (Thanatos) imbues all of them

Let’s review an important inner object: the persecutory object.

Persecutory object is an internal object that represents the intimate partner or others.

If others, the intimate partner can collude in the delusion or oppose it. If she opposes it, she becomes the persecutory object.

If the intimate partner is the persecutory object, she can collude (accept her role and act accordingly to conform to expectations) or oppose it by redirecting the suspicions at others, including family members.

Victims of prolonged abuse often introject (internalize) their abusers and convert them into permanent persecutory objects. Henceforth, they trauma bond with this inner tormenting voice even when the original bully is long out of their lives.

This conflation of external and external and the paranoid ideation or persecutory delusions that it provokes (referential ideation, hypervigilance) virtually guarantees collapse.

1. **Collapsed States**

Collapse is a dramatic and abrupt reduction in self-efficacy, sense of agency, and personal autonomy.

All narcissists are collapsed, end up evolving Len Sperry’s schizoid style, and suffer from the Impostor Syndrome.

Narcissist collapsed state is outcome of such disruption in inner dialog: sadistic perfectionist inner critic superego sets the narcissist up for failure by posing unattainable unrealistic goals.

In adversity and crisis, the narcissist becomes psychotic (Kernberg): he misperceives this voice (persecutory object) as external (projects it) and feels victimized.

We project our inner dialog whenever we are triggered to revividness (i.e., an external object INITIATES direct communication with internal object). PTSD is a form of psychosis (hence flashbacks).

We introject inner dialog whenever we are traumatized (i.e., internal object INITIATES communication with an external object), which is why trauma leads to narcissism (CPTSD/BPD).

Solution: Splitting.

Splitting leads to dissociation:

Depersonalization, derealization (where the splitting prevents the construction of a healthy inner dialogue): we are all bad and "killed" symbolically); OR amnesia (we are all good and environment "killed" symbolically).

Addictions provide such dissociated splitting in neurotypicals.

**Collapsed Covert NPD**

Collapse leads to mortification and disables the False Self.

This immediately results in ostentatious indifference (“doormat”), no enforced boundaries, extreme conflict aversion, and the amelioration or reduction of dissonant anxiety.

The Covert than embarks on reconstructing the False Self via antisocial displays of defiant, impulsive, reckless, and callous misconduct.

Another round of collapse and mortification follow and the False Self is restored.

The Covert than reverts to Overt NPD.

**The Collapsed Histrionic** (Collapsed HPD)

B is a woman with body image (somatoform) issues and a low sense of self-worth. Yet, she still needs men and uses them to regulate her flagging self-esteem and deficient self-confidence. This creates a permanent dissonance and anticipatory anxiety as such a woman expects fully to be rejected and humiliated by men.  
  
Low self-esteem often leads to an impaired reality test: B misreads environmental, social, and sexual cues and often ends up being mocked, shunned, abused, or sexually assaulted by men  
  
She compensates for her insecurities with brazen defiance and grandiosity as well as substance abuse, all of which compound her ability to properly gauge reality  
  
Her feelings of inferiority and inadequacy lead B to social withdrawal and reclusiveness. She rarely dates men and when she does, she aggresses against, pushes away, and abuses “alpha” males, even when they are genuinely interested in her (“preemptive abandonment”).

Instead, B picks up "safe" males: weak, ugly losers, who are very unlikely to painfully reject her.

Histrionic Personality Disorder (HPD) combines traits of both Narcissistic and Antisocial (psychopathic) personality disorders. It, therefore, stands to reason that these three cluster B ("dramatic") stalwarts share the same etiology and psychodynamics.  
  
Many histrionics use the opposite sex - their attention, infatuation, and arousal - to regulate their emotions, moods, affect, and sense of self-worth (self-esteem and self-confidence). Potential mates are their "histrionic supply".

Similarly, when roundly and resolutely rejected, collapsed histrionics react with "histrionic rage". They resort to in your face defiance, often by triangulating with a third person in order to provoke jealousy or grievously hurt the frustrating and rejecting object.  
  
The histrionic's aggression is focused on restoring his or her grandiosity via a new and ostentatious sexual conquest. But it can and does wear many other, mostly passive-aggressive or reckless forms or behaviors: compulsive shopping ("shopaholism"), gambling, lying, sabotaging, procrastinating, substance abuse, verbal abuse, brutal honesty, offensive humor and mockery, and so on.

When a woman with mental health issues is sexually or otherwise rejected by her intimate partner she acts out in one of two typical ways.

This is especially true if the husband also justifies his sadistic cruelty by adding abuse & overt humiliation to injury: "You are ugly, you do not turn me on, you do not know how to be a woman, you are stupid & repulsive, you are whorish, you do not understand my sexual & psychological needs."

The union then devolves into a power match. The personality disordered (narcissistic, histrionic, borderline) woman seeks to obtain two goals to redress her grievances & her sense of offended justice.  
  
The first goal is to disprove her partner's evaluation of her & restore her self-esteem & self-confidence by proving mainly to herself how other men desire her. This she accomplished by becoming a flirtatious, promiscuous & seductive cockteaser.  
  
The second goal is to punish her (non) intimate partner by rendering "his woman" (herself) a slut - or by transmogrifying into a non-woman.  
  
By sexually egregiously misbehaving with multiple men, the rejected woman transforms herself into a "whore". This is her way to penalize her abuser by devaluing & debasing herself (his "property").

But some women choose the exact opposite solution: they passive-aggressively stop being women altogether. In a way, they unconsciously adopt the abuser's view of them as repellent & validate it. They neglect their appearance, abandon their personal hygiene, dress in tattered & shabby garb, put on no make up, are physically inert, and neglect their duties - including in business, childbearing & childrearing.

This is their way of defying their mean and nasty partner: "You say that I am not a woman? Well, here you are, I stop being one". These women eradicate their femininity & womanhood as a way of getting back at their mistreating spouse.

1. **NARCISSISTIC MORTIFICATION**

Narcissistic mortification is “intense fear associated with narcissistic injury and humiliation ... the shocking reaction when individuals face the discrepancy between an endorsed or ideal view of the self and a drastically contrasting realization” (Freud in Ronningstam, 2013).

Rothstein (ibid.): “... fear of falling short of ideals with the loss of perfection and accompanying humiliation”.

This fear extends to intimacy in interpersonal relationships (Fiscalini), unrealized or forbidden wishes and related defenses (Horowitz), and, as Kohut so aptly summarized it: “fear associated with rejection, isolation, and loss of contact with reality, and loss of admiration, equilibrium, and important objects.”

Kernberg augmented this list by adding: “fear of dependency and destroying the relationship with the analyst, fear of retaliation, of one’s own aggression and destructiveness, and fear of death.”

Narcissistic mortification, is, therefore, a sudden sense of defeat and loss of control over internal or external objects or realities, caused by an aggressing person or a compulsive trait or behavior. It produces disorientation, terror (distinct from anticipatory fear), and a “damming up of narcissistic (ego-)libido or destrudo (mortido) is created” (Eidelberg, 1957, 1959).

The entire personality is overwhelmed by impotent ineluctability and a lack of alternatives (inability to force objects to conform or to rely on their goodwill). Mortification reflects the activity of infantile strategies of coping with frustration or repression (such as grandiosity) and their attendant psychological defense mechanisms (for example, splitting, denial, or magical thinking).

Early childhood events of mortification are crucial in teaching the baby to distinguish between the external and the internal, establish ego boundaries, recognize his limitations, delay gratification, and select among options. Of course, it is possible to be overtaken by multiple internal and external mortifications (“traumas”) to the point that repression and dissociation become indispensable as well as compensatory cognitive deficits (omnipotent or omniscient grandiosity, entitlement, invincibility, paranoid projection, and so on).

Bergler and Maldonado reminds us that pathological (secondary) narcissism is a reaction to the loss of infantile omnipotent delusions and of a good and meaningful object, associated in the child’s mind with ideals, a loss which threatens “continuity, stability, coherence, and wellbeing” of the self.

In adulthood, a self-inflicted internal mortification, usually founded on these distortions of reality, compensates for an external one and disguises it and vice versa: an internal mortification such as an autoplastic defense (“It is all my fault, I made it happen”) restores a grandiose illusion of control over an external mortification while a persecutory delusion (an external mortification) replaces an internal mortification (“I have evil and hateful thoughts towards people”).

But, the only true solution to a mortification is the regaining of control and, even then, it is only partial as control had clearly been lost at some point and this cataclysm can never be forgotten, forgiven, or effectively dealt with.

The need to reframe narcissistic mortification is because – as an extreme and intolerably painful form of shame-induced traumatic depressive anxiety – it threatens the integrity of the self, following a sudden awareness of one’s limitations and defects (Lansky, 2000 and Libbey, 2006).

When they are faced with their own hopeless “unlovability, badness, and worthlessness”, mortified people experience shock, exposure, and intense humiliation, often converted to somatic symptoms. It feels like annihilation and disintegration.

Hurvich (1989) described it as: “a virtually intolerable intolerable experience of terror, fright, or dread related to a sense of ‘overwhelmed helplessness, reminiscent of the overwhelmed helplessness of infancy ... annihilation anxiety ... ‘Fear of the Disintegration of the Self or of Identity’” (Libbey, 2006).

Libbey postulates that narcissistic mortification is a “sudden loss of the psychic sense of self, which occurs simultaneously with a perception that the tie to a self-object (Kohut, 1971) is threatened.” Kohut added: “if the grandiosity of the narcissistic self has been insufficiently modified...then the adult ego will tend to vacillate between an irrational overestimation of the self and feelings of inferiority and will react with narcissistic mortification to the thwarting of its ambitions.” Object relations theorists concurred: Bion’s “nameless dread”, Winnicott’s “original agonies” of the collapse of childish consciousness as it evolves and mature into an adult’s.

This may have to do with a lack of evocative constancy: “The capacity to maintain positively toned images of self and others with which to dispel feelings of self-doubt (Adler and Buie, 1979). Self-reflexivity – “the ability to oscillate easily among varying perspectives on the self” (Libbey, 2006) crucially relies on the smooth operation of evocative constancy (Bach, 1978, Broucek, 1982).

Libbey describes two strategies that narcissists use to restore a modicum of cohesiveness to the self. The “deflated” narcissist debases the self and inflates or idealizes “the object in order to reacquire it ... It can include, for example, atonement, aggrandizement of the other, self-punishment, and self-flagellation ... designed to appease and hold on to selfobjects." Anna Freud presaged this with her concept of “altruistic surrender” (self-sacrificial and, therefore, self-disparaging altruism).

Another strategy, of “inflated” narcissists and revenge seekers, involves “debasement of the object ... attacking the other, in order to aggrandize and re-stabilize the self. There is always a winner and a loser. Such narcissists 'fight fire with fire' or 'take an eye for an eye' ... 'arighting the scales of justice.' There are only winners and losers, and they must be the winners ... (Shamers) are also adept at short-circuiting the plunge into mortification altogether, preemptively expelling impending feelings of shame and defectiveness by humiliating the other ... Whichever route is taken, the individual cannot recover from mortification until a tolerable, familiar self-state is re-acquired, either by re-establishing the other as an approving object, or by destroying the other, temporarily or permanently ... narcissistic conceit, designed to project the defective self-experiences onto self-objects.”

Narcissistic mortification is an extreme form of decompensation when all the narcissist’s defenses crumble as a result of a deeply traumatizing, challenging, and humiliating event. Mortification, when rendered external leads to paranoia and when internal leads to depression.

**Summary**

The narcissist copes with mortification in one of two ways:  
  
1. He renders it external, casting himself as the hapless victim of malicious, envious, mentally ill people. This preserves his self-image as good and morally upright, but leads to depression.  
  
2. He renders it internal and accepts his contribution to the mortifying event and his ensuing responsibility. Such reframing restores his sense of mastery and control over the situation and others but results in hypervigilance, paranoid and referential ideation, and persecutory delusions (neurotic autoplastic solution).

Both choices result in hypervigilance, paranoid and referential ideation, and persecutory delusions.  
Collapse and mortification, therefore, seem to regulate both affectivity (moods) and switching between self-states (“diagnoses”).

Mortification proceeds this way: event, dissociation, processing the event cognitively and emotionally (unconscious), choice of external or internal response.

Trauma has a different path: event, automatic (traumatic) response, processing the event cognitively and emotionally (unconscious), dissociation.

Only mortification makes the narcissist feel alive and sexually aroused: sadism, masochism, and libido maximized and a recreation of the primary unresolved conflict. In the mortification crisis, the narcissist sees himself through other people’s eyes and stands a chance to free himself of the shackles of his taskmaster, the [False Self](https://samvak.tripod.com/faq48.html), via re-traumatization.

This could lead to finally force the narcissist to accept and to internalize the insight that he is "very sick": in itself a mortification, it is the first step in a therapeutic process of healing - or of giving up on himself and on life.

Treatment should focus on converting mortification to shame “which includes the capacity to tolerate it and to use it as a signal ... Both defensive styles require continued dependence on selfobjects and must be mounted again and again. Tolerating bearable shame can make self-appraisal and self-tolerance possible, ultimately leading to psychic separation and self-reliance.”

But narcissistic mortification is a universal reactive pattern.

**Mortification in Borderline Personality Disorder (BPD)**

The False Self in [Borderline Personality Disorder (BPD)](https://samvak.tripod.com/personalitydisorders18.html) is akin to the host personality in Dissociative Identity Disorder: to moderate and to switch between self-states is a secondary psychopath and to regulate the resulting repression, denial, splitting, dissociation, and other infantile defenses in an attempt to maintain self-constancy rather than object constancy.

Consequently, the Borderline patient seeks mortification in order to feel alive, not free: she seeks to introduce novelty, thrills, and reckless risk taking into her life via chaotic drama. It is the only way she can experience transformation and also the only method open to her when she feels like self trashing, self-punishment, or self-mutilation). Mortification in Borderlines is self-inflicted in preemptive abandonment and the Borderline then copes by becoming dissociative (disappearing) or by displaying traits and behaviors of a secondary psychopath (making others disappear), or, more commonly, both.

1. **MISSING COVERT STATES**

Covert narcissist (fragile, vulnerable, closet, shy, introverted, etc.) well described in the literature, starting with Cooper and Akhtar (1989) and Masterson (1993).

“Numerous theorists have suggested categorical subtypes of narcissism capturing the Distinction between the more overt, grandiose presentation, as described in the DSM, and

the more covert, vulnerable presentation. However, recent formulations note that both grandiose and vulnerable presentations can have overt and covert manifestations (Cain,

Pincus, & Ansell, 2008).

Although many contemporary theorists and researchers have emphasized categorical distinctions among narcissistic individuals, many other clinical writers have stressed that grandiose mental states oscillate or co‐occur with vulnerable mental states. Kernberg (1975/1985) noted that the grandiose and vulnerable expressions may reflect different clinical manifestations of the disorder, with some traits being overt and others covert. He contended that narcissistic individuals hold contradictory views of the self that vacillate between the expression of grandiose and vulnerable aspects.”

**(The Wiley Encyclopedia of Personality and Individual Differences, October 2020)**

Two examples: vert BPD and Covert AsPD

**Covert Borderline Personality Disorder (BPD)**

The shy or quiet borderline internalizes her struggles rather than externalize them. She becomes the exclusive target of her own turmoil. She “acts in”.

Both the classic and covert borderline (many of the latter are men) act out.

Here is a table which compares the clinical features of the two subtypes.

It is based on the schematic present by Arnold M. Cooper and S. Akhtar in 1989 for classic vs. cover narcissist.

|  |  |  |
| --- | --- | --- |
|  | **Covert/Antisocial** | **Classic/**  **Dysregulated** |
| **Self-Concept**  **And Emotional Regulation** | 2. false self grandiosity;    3. preoccupation with fantasies of outstanding love; undue sense of uniqueness; feelings of entitlement; alloplastic defenses;      4. internal locus of control; seeming self-sufficiency;                    9. mood lability;    10. emotional dysregulation and rationalization or reactance and defiance, contumaciounsess;        12. low boredom threshold and tolerance;        14. externalizing-internalizing;    15. No suicidal ideation, aggression other-directed;        16. No self-mutilation, hypochondriasis, addictive behaviors;    17. dissociative self-states, mainly: selective attention, confabulation, repression or denial, primary psychopathic protector | 1. identity diffusion;    2. inferiority;    3. morose self-doubts and ego-dystony or ego discrepancy (“wrongness”), autoplastic defenses;      4. external locus of control;    5. marked propensity toward feeling ashamed, guilty, or to blame;  6. fragility, vulnerability;    7. relentless search for safety and completion;    8. marked sensitivity to criticism and realistic setbacks;    9. mood lability;    10. emotional dysregulation and numbing and dysempathy;    11. alexithymia;    12. low frustration threshold and tolerance;    13. depression and anxiety;    14. internalizing-externalizing;    15. suicidal tendencies;          16. self-harm and substance abuse or self-trashing (like egregious promiscuity)    17. dissociative self-states, mainly: realization, depersonalization, or amnesia |
| **Interpersonal**   **Relationships** | 1. paranoid ideation;      2. numerous but shallow relationships;      intense need for love from others, people pleasing;    lack of real empathy in primary psychopathic phase;    valuing of children over spouse in family life;    7. inability to genuinely participate in group activities;          9. passive-aggressive, sullen, surly, self-denying, behaviors; cunning and premeditated malevolence;    10. intermittent reinforcement;      11. scorn for others, often masked by pseudohumility;    12, 17. histrionic attention seeking;      13. recklessness aimed at hurting or affecting others;      14. sadistic-punitive or goal-oriented triangulation;        15, 16. object inconstancy: idealize-devalue-discard-revert or replace | 1. inability to genuinely depend on others and trust them, hypervigilance;    2. instant or fake intimacy (sometimes in casual sex)    3. abandonment anxiety (impostor syndrome);    4. engulfment anxiety and fear of intimacy;    5. rejection sensitivity;    6. effortful control;    7. chronic envy of others talents, possessions, and capacity for deep object relations;    8. lack of regard for generational boundaries;    9. disregard for others’ time, limitations, obligations, and resources (unreasonably demanding);    10. unpredictable,      11. explosive behavior;      12. impulsivity;      13. recklessness;        14. interpersonal triangulation;    people pleasing;    15. approach-avoidance repetition compulsion and preemptive abandonment;    16. object inconstancy;    17. drama queens |
| **Social**    **Adaptation** | 2. Socially charming, charismatic;    3. consistent hard work done mainly to seek admiration (pseudo- sublimation);    4. intense ambition;    5. often successful;        7. preoccupation with appearances | 1. nagging aimlessness;    2. social anxiety;    3. shallow vocational commitment;      4. dilettante-like attitude;    5. multiple but superficial interests;    6. chronic boredom;    7. aesthetic taste often ill-informed and imitative |
| **Ethics,**    **Standards,**    **and** **Ideals** | 1. idiosyncratically and unevenly moral, caricatured modesty, activism and apparent enthusiasm for sociopolitical affairs;    2. inordinate ethnic and moral relativism;    3. pretended contempt for money in real life, feigned spirituality and “guru” status;  4. irreverence toward authority | 1. readiness to shift values to gain favor;        2. pathological lying;    3. materialistic lifestyle;    4.delinquent tendencies; |
| **Love**    **and**    **Sexuality** | 1.marital instability;    2. cold and greedy seductiveness;        3. extramarital affairs and promiscuity;      4. uninhibited sexual life | 1. inability to remain in love;    2. impaired capacity for viewing the romantic partner as a separate individual with his or her own interests, rights, and values;    3. inability to genuinely comprehend the incest taboo;    4. occasional sexual perversions |
| **Cognitive**    **Style** | 1. dichotomous thinking;    2. splitting;        4. impressively knowledgeable;      5. egocentric perception of reality;    6. fondness for shortcuts to acquisition of knowledge    7. decisive and opinionated;    8. love of language, often strikingly articulate; | 1. dichotomous thinking;    2. splitting;    3.  catastrophizing;    4. knowledge often limited to trivia (headline intelligence);    5. forgetful of details, especially names;    6. impaired in the capacity for learning new skills;    7. tendency to change meanings of reality when facing a threat to self-esteem;    8. language and speaking used for regulating self-esteem |

**Covert AsPD**

The Covert Antisocial or Psychopath is a composite of Covert NPD and Classic BPD which together yield secondary psychopathy. This raises the distinct possibility that AsPD is not clinical entity or diagnostic category but a culture-bound, derivative comorbidity.

Borderline and Histrionic personality disorders may be manifestations in [females of secondary type psychopathy](https://www.instagram.com/p/B9l5Fl3guE2/) (as measured by Factor 2 of the PCL-R test). In other words: Borderline and Histrionic women may actually be psychopaths. A growing body of recent studies supports this startling conclusion. Survivors of CPTSD also manifest psychopathic and narcissistic behaviors (overlay)  
  
Intimate partners won't not surprised: impulsivity, defiant grandiosity, antisocial and interpersonal aggression, manipulativeness, dysregulated negative emotionality, lack of object constancy (object impermanence), attachment dysfunctions, hostility, splitting (dichotomous thinking), high levels of distress, anxiety, depression, and substance abuse are all typical of and common among secondary psychopaths - and among Borderlines. These women also defy gender roles and behavioral norms (act masculine). But the Borderline adds a twist to this cocktail: dissociation. Whenever stress levels and inner dissonance become intolerable, she hands over control to her inner psychopath, depersonalizes, derealizes, or develops amnesia.

**CASE STUDIES**

**Case Study 1: collapsed somatic narcissist**

D is in his 40s, a hotelier. He is a is incapable of leveraging his good looks, sculpted musculature, and sexual prowess to obtain narcissistic supply. If he is endowed with intelligence, he switches to the cerebral mode. If not, he becomes covert.  
  
The etiology of such failure is complex. The narcissist may feel that he is engaging in a forbidden competition with a dominant parental figure. Or, he may have been rewarded in childhood for intellectual accomplishments while sex was decried as “dirty”.  
  
In most cases, the failure is that of gender differentiation: the collapsed somatic narcissist is a latent homosexual or of fluid psychosexuality.  
  
One possible outcome is celibacy or sexlessness within a relationship. Another solution is promiscuity (usually coupled with substance abuse). If the narcissist fails at both the somatic and the cerebral types, he undergoes mortification and becomes covert for good. If he has strong histrionic or borderline features, he is more likely to become a psychopath (secondary or primary) or a covert borderline.

**Case Study 2: Collapsed Overt Narcissist**

"Failed" narcissist is a clinical term coined by Grotstein to describe a phase in the formation of borderline personalities.

N is a 40 years old man, married, with 2 children, self-srtyled businessman.  
  
N is angered by a lack of narcissistic supply & directs some of this fury inwards, punishing himself for his "failure". This masochistic behavior has the added "benefit" of forcing the narcissist's closest to pay him the attention that he craves.  
  
By undermining his work, his relationships, and his efforts, the increasingly fragile narcissist avoids additional criticism and censure (negative supply). Self-inflicted failure is the narcissist's doing and thus proves that he is the master of his own fate. So, collapsed narcissists act carelessly, withdraw in mid-effort, are constantly fatigued, bored, or disaffected and thus passive-aggressively sabotage their lives. Their suffering is defiant and by "deciding to abort" they reassert their omnipotence.  
  
The narcissist's pronounced and public misery and self-pity are compensatory and "reinforce (his) self-esteem against overwhelming convictions of worthlessness" (Millon, 2000). His tribulations and anguish render him, in his eyes, unique, saintly, virtuous, righteous, resilient, and significant. They are, in other words, self-generated narcissistic supply.  
  
Thus, paradoxically, the worst his anguish and unhappiness, the more relieved and elated such a narcissist feels!  
  
In extremis, when all these default behaviors and solutions fail, or when only negative, fake, low-grade, and static narcissistic supply is to be had, the narcissist "falls apart" in a process of disintegration known as decompensation (the inability to maintain psychological defenses in the face of mounting stress.) This is accompanied by “acting out”: when an inner conflict (most often, frustration) translates into aggression. It involves acting with little or no insight or reflection and in order to attract attention and disrupt other people's cosy lives.

**MORTIFICATION**

**Case Study 1**

A patient craves love and intimacy (also as reified by sex), but he hates himself for this life-threatening vulnerability. He uses projective identification and projective introjection coupled with persecutory paranoia: he egregiously misbehaves and so forces others to hate him and to act against him or perceives them as hateful with some justification. This way, he prevents the formation of love and intimacy as well as sexual relations. He kills two birds with one stone: he avoids acknowledging his own suicidal self-hatred and he sidesteps being vulnerable to a dangerous level (again: suicidal).

**Case Study 2**

The patient idealizes a potential partner, but rejects, verbally abuses, withholds, and humiliates him. He reacts by picking up another partner.

This challenges her omnipotence (she feels helpless, humiliated), omniscience (failed to spot his “conspiracies”, gullibly trusted his “lies” about himself and about their interactions), perfection (he rejected her), superiority (he chose an inferior or superior alternative over her), brilliance (the incident proved that he regards her as a damaged fool), and self-perception as loved and protected child (everyone involved envied and hated her).

She repressed the intolerable external narcissistic mortification (the public exposure of her glaring unfixable inadequacies, limitations, and defects) under an internal one (It is all my fault, I made her misbehave) in a failed attempt to restore her grandiose omnipotence.

She then reverted to paranoia, replacing one external mortification with another (Evil people were out to hurt her) in a failed attempt to not feel hopelessly damaged and evil (to restore ego syntony and assuage her pain and desperation: I am OK, They are Evil).

She remained in touch with him in order to support with evidence both these two alternative mortifications.

She ghosted him only once she succeeded to integrate the two alternative mortifications, thereby fully accounting for all the events in a realistic and satisfying manner (My misbehavior did cause him to overreact, but his egregious, disproportional, and unjustified misconduct is because he is a psychopath and evil, his new partner is an envious opportunist, and the witnesses are  malicious haters) AND restoring grandiosity by vindictively punishing everyone involved.

**Bibliography**

**Online**

[***Comorbidity in Personality Disorders***](http://www.narcissistic-abuse.com/faq82.html)

***McDowell, Maxson J. (2002)*** [***The Image of the Mother's Eye: Autism and Early Narcissistic Injury***](http://cogprints.ecs.soton.ac.uk/archive/00002593/01/eye22fixed_by_cogprints.html) ***, Behavioral and Brain Sciences (Submitted)***

***Benis, Anthony - "Toward Self & Sanity:  On the Genetic Origins of the Human Character" -*** [***Narcissistic-Perfectionist Personality Type (NP) with special reference to infantile autism***](http://narcissism.homestead.com/nptype.html)

***Stringer, Kathi (2003)*** [***An Object Relations Approach to Understanding Unusual Behaviors and Disturbances***](http://www.toddlertime.com/general/disturbances.htm)

***James Robert Brasic, MD, MPH (2003)*** [***Pervasive Developmental Disorder: Asperger Syndrome***](http://www.emedicine.com/ped/topic147.htm)

**Print References and Bibliography**

1. [Stormberg D, Roningstam E, Gunderson J, Tohen M. Pathological Narcissism in Bipolar Disorder Patients. Journal of Personality Disorders.1998;12:179-185.](https://guilfordjournals.com/doi/abs/10.1521/pedi.1998.12.2.179)
2. [Roningstam E. Pathological Narcissism and Narcissistic Personality Disorder in Axis I Disorders. Harvard Review of Psychiatry.1996;3(6):326-340.](https://www.tandfonline.com/doi/abs/10.3109/10673229609017201)
3. [Alford, Fred C. Narcissism: Socrates, the Frankfurt School and Psychoanalytic Theory - New Haven and London, Yale University Press.1988.](https://drirene.com/varbib.php)
4. [Fairbairn W. R. D. An Object Relations Theory of the Personality .1954.](https://books.google.co.in/books?id=n4gRBgAAQBAJ&pg=PT928&lpg=PT928&dq=-+An+Object+Relations+Theory+of+the+Personality+-+New+York,+Basic+Books,+1954+Freud+S.+-+Three+Essays+on+the+Theory+of+Sexuality+(1905)+-+Standard+Edition+of+the+Complete+Psychological+)
5. [Freud S. Three Essays on the Theory of Sexuality . Standard Edition of the Complete Psychological Works of Sigmund Freud.1905;7.](https://www.sas.upenn.edu/~cavitch/pdf-library/Freud_SE_Three_Essays_complete.pdf)
6. [Freud S. On Narcissism.14:73-107.](https://books.google.co.in/books?id=n4gRBgAAQBAJ&pg=PT928&lpg=PT928&dq=-+An+Object+Relations+Theory+of+the+Personality+-+New+York,+Basic+Books,+1954+Freud+S.+-+Three+Essays+on+the+Theory+of+Sexuality+(1905)+-+Standard+Edition+of+the+Complete+Psychological+)
7. [Golomb E. Trapped in the Mirror : Adult Children of Narcissists in Their Struggle for Self - Quill.1995.](https://www.iberlibro.com/servlet/BookDetailsPL?bi=1115940704&tab=1&searchurl=)
8. [Greenberg JR, Mitchell SA. Object Relations in Psychoanalytic Theory .1983 .](https://www.hup.harvard.edu/catalog.php?isbn=9780674629752&content=reviews)
9. [Grunberger B. Narcissism: Psychoanalytic Essays . New York, International Universities Press .1979](https://journals.sagepub.com/doi/abs/10.1177/000306518403200120?journalCode=apaa) .
10. [Guntrip H . Personality Structure and Human Interaction. New York, International Universities Press.1961.](https://psycnet.apa.org/record/1962-04896-000)
11. [Horowitz MJ. Sliding Meanings: A defense against threat in narcissistic personalities - International Journal of Psychoanalytic Psychotherapy.1975,Feb;4:167-180](https://www.researchgate.net/publication/21996243_Sliding_Meanings_A_Defense_Against_Threat_in_Narcissistic_Personalities).
12. [Jacobson E. The Self and the Object World. New York, International Universities Press.1964 .](https://en.wikipedia.org/wiki/Edith_Jacobson)
13. [Kernberg O. Borderline Conditions and Pathological Narcissism. New York, Jason Aronson. 1975 .](https://www.cambridge.org/core/journals/psychological-medicine/article/borderline-conditions-and-pathological-narcissism-by-otto-kernberg-pp-361-1500-jason-aronson-new-york-1975-psychotherapy-of-the-borderline-adult-by-j-f-masterson-pp-377-1750-brunnermaze)
14. [Trust MK, The Writings of Melanie Klein - Ed. Roger Money-Kyrle - 4 vols. - New York, Free Press.1964-75.](The%20Writings%20of%20Melanie%20Klein%20-%20Ed.%20Roger%20Money-Kyrle%20vol%204)
15. [Kohut H. The Analysis of the Self - New York, International Universities Press,1971.](https://www.scirp.org/(S(i43dyn45teexjx455qlt3d2q))/reference/ReferencesPapers.aspx?ReferenceID=1464977)
16. Lasch C. The Culture of Narcissism. New York, Warner Books,1979.
17. Alexander L, Narcissism : Denial of the True Self - Touchstone Books, 1997 .
18. Millon T, Davis RD. Disorders of Personality: DSM IV and Beyond ,2nd ed. John Wiley and Sons, 1995.
19. [Millon T. Personality Disorders in Modern Life - New York: John Wiley and Sons. 2000.,Aug;188(8):558.](https://journals.lww.com/jonmd/Fulltext/2000/08000/Personality_Disorders_in_Modern_Life_.22.aspx)
20. [Ronningstam E. Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications . American Psychiatric Press.1998.](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3330532/)
21. [Ronningstam E. Pathological Narcissism and Narcissistic Personality Disorder in Axis I Disorders. Harvard Review of Psychiatry,1996,Apr;3(6): 326-340.](https://www.ncbi.nlm.nih.gov/pubmed/9384963)
22. Rothstein A. The Narcissistic Pursuit of Reflection .International Universities Press.1984.
23. [Lester S. Narcissistic Personality Disorders - A Clinical Discussion. Journal of Am. Psychoanalytic Association.1974,Apr;22(2):292-306.](https://www.ncbi.nlm.nih.gov/pubmed/4414775)
24. [Daniel S. The Interpersonal World of the Infant. A View from Psychoanalysis and Developmental Psychology.1985.](file:///C:\Users\Admin21\Downloads\9780429482137_googlepreview.pdf)
25. [David S, Roningstam E, Gunderson J, Tohen M. Pathological Narcissism in Bipolar Disorder Patients. Journal of Personality Disorders. 1998;12(2):179-185.](https://guilfordjournals.com/doi/abs/10.1521/pedi.1998.12.2.179)
26. [Vaknin S Malignant Self Love – Narcissism Revisited, 10th revised impression – Skopje and Prague. Narcissus Publications.2015.](http://samvak.tripod.com/thebook.html)
27. Zweig P. The Heresy of Self-Love: A Study of Subversive Individualism.1968.

**Biography**

****

Sam Vaknin is the author of "Malignant Self-love: Narcissism Revisited" and other books about personality disorders. His work is cited in hundreds of books and dozens of academic papers:  
  
<http://www.narcissistic-abuse.com/mediakit.html>  
  
He spent the past 6 years developing a treatment modality for Narcissistic Personality Disorder (NPD). Over the years, with volunteers, it was found to be effective with clients suffering from a major depressive episode as well.  
  
**Presenting author details**

* Full name: Sam Vaknin
* Email: samvaknin@gmail.com
* Contact number: +38978319143, +79884640967
* Research Interest: Personality Disorders
* Current designation: Professor
* Twitter account: http://www.twitter.com/samvaknin
* Facebook account: http://www.facebooks.com/samvaknin
* LinkedIn account: https://www.linkedin.com/in/samvaknin

Category: Paper/Poster