

# Subtypes, Dimensions, Levels, and Mental States in Narcissism and Narcissistic Personality Disorder

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Various conceptualizations of subtypes, levels, and dimensions of narcissism and narcissistic personality disorder (NPD) are considered with a particular focus on overt grandiose presentations and covert vulnerable presentations. Evidence supporting this distinction and clinical vignettes to illustrate it are presented as well as their implications for clinical work with NPD patients. The research and clinical evidence points to the conclusion that these broad categorical subtypes are better conceptualized as dimensions on which individual patients vary on relative levels, thus suggesting that grandiose and vulnerable presentations represent two sides of the same coin. A case example and clinical implications are provided and discussed. © 2012 Wiley Periodicals, Inc. *J. Clin. Psychol. In Session* 00:1–12, 2012.

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Beginning with its inclusion in the Diagnostic and Statistical Manual (DSM; 1968, 1980, 1994, 2000), narcissistic personality disorder (NPD) has been conceptualized predominately by its overt grandiose features. However, the definition of NPD articulated in the DSM-III and its successors, DSM-III-R and DSM-IV, has been criticized for failing to fully capture the intended clinical phenomena (Cooper & Ronningstam, 1992; Gabbard, 1989; Gunderson et al., 1991). These authors have noted that the DSM criteria have focused narrowly on aspects of the conceptual approaches of Kernberg and Millon, emphasizing the more overt form of narcissism. However, theoretical and empirical work is now converging to suggest that NPD is not a homogenous disorder and subtypes likely exist within this group. Distinguishing between NPD subtypes, dimensions, and levels may assist with diagnostic clarity, assessment, course, and treatment (Levy, Reynoso, Waserman, & Clarkin, 2007).

In this article, I will describe the theoretical and empirical work that informs the conceptualization of subtypes and related issues. The discussion of subtypes will focus primarily on the distinction between an overt or grandiose type versus a more covert vulnerable type. However, other subtype distinctions will be addressed. This discussion will be followed by an examination of mental states in narcissism as well as distinctions between levels and dimensions of narcissism. The case will be made that rather than conceptualizing NPD through the lens of subtypes, it is more useful to consider individual patients as varying on relative levels of overt and covert dimensions that operate not only independently but also in relation to one another. For example, although some patients can be characterized as predominantly grandiose or vulnerable, vacillations between these two dimensions or mental states are nevertheless standard. Finally, after a brief discussion of the relevant outcome literature, a case illustration will be presented to clarify how attention to the dynamics of grandiose and vulnerable dimensions can inform clinical practice.

## *Subtypes*

A number of prominent theorists have suggested various subtype distinctions of narcissism. Most of these subtypes can be conceptualized as a distinction between the more overt/grandiose presentation and the more covert/vulnerable presentation. The overt form has also been referred

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to as grandiose, oblivious, willful, exhibitionist, thick-skinned, or phallic; the covert form has been referred to as vulnerable, hypersensitive, closet, or thin-skinned (Akthar & Thomson, 1982; Bateman, 1998; Britton, 2000; Cooper, 1981; Gabbard, 1989; Masterson, 1981; Rosenfeld, 1987; Wink, 1991). The overt type is characterized by grandiosity, attention seeking, entitlement, arrogance, and little observable anxiety. Consistent with the description of NPD in the DSM, these individuals can be socially charming despite being oblivious of others' needs, interpersonally exploitative, and envious. In contrast, the covert type is hypersensitive to others' evaluations, inhibited, manifestly distressed, and outwardly modest. Gabbard (1989) described these individuals as shy and "quietly grandiose," with an "extreme sensitivity to slight," which "leads to an assiduous avoidance of the spotlight" (p. 527). The covert type can also express grandiosity through an overidentification with suffering and distress (e.g., they suffer more than anyone else). Individuals with both types of narcissism are extraordinarily self-absorbed and harbor unrealistically grandiose expectations of themselves.

Other distinctions in the expression of NPD have been noted. For example, Bursten (1973) proposed four types of narcissistic personalities: (a) craving individuals, who are clinging, demanding, and needy; (b) paranoid individuals, who are critical and suspicious; (c) manipulative individuals, who derive satisfaction from conscious and deliberate deception of others; and (d) the phallic narcissist who is aggressive, exhibitionistic, reckless, and daring. These distinctions seem overly broad and include characteristics of individuals with other disorders, but generally correspond to the overt-covert distinction (e.g., paranoid and phallic correspond to the grandiose type and craving corresponds to the vulnerable type).

Kohut and Wolf (1978) described three subtypes based on interpersonal relationships: (a) merger-hungry individuals who must continually attach and define themselves through others; (b) contact shunning individuals who avoid social contact because of fear that their behaviors will not be admired or accepted; and (c) mirror-hungry individuals who tend to display themselves in front of others. Implicit in each of these subtypes is a condensation between overt and covert dynamics. For example, contact shunning individuals believe they should be admired, tend to be dismissive of others, and may not show observable anxiety, yet they can be very anxious for others' acceptance.

Yet another attempt at subtyping narcissistic individuals was proposed by Millon (1969, 1981, 1998), who conceptualized NPD as a prototype and distinguished among five subtypes: (a) an amorous subtype that shows prominent histrionic features and is exhibitionistic; (b) an unprincipled type that is exploitive and shows antisocial features; (c) a compensatory type that shows elevations in avoidant and/or passive-aggressive traits; (d) an elitist type that tends toward self-promotion and has an inflated self-concept; and (e) a fanatic type that is characterized by paranoid features and omnipotence. These subtypes tend to emphasize the overt/grandiose aspects of NPD.

To date, little research has been performed to establish the reliability or validity of these subtypes beyond the overt-covert distinction. This specific distinction has been empirically supported in a number of studies (Dickerson & Pincus, 2003; Hendin & Cheek, 1997; Hibbard & Bunce, 1995; Rathvon & Holmstrom, 1996; Rose, 2002; Wink, 1991, 1992). For example, Wink (1991) identified two orthogonal dimensions of narcissism: vulnerable-sensitive and grandiose-exhibitionist. And, in a 20-year longitudinal study, Wink (1992) identified three patterns of narcissism—hypersensitive (vulnerable), willful (grandiose), and autonomous (or healthy)—that showed quite distinct patterns of personality change during the transition from college to midlife.

In their early 40s, hypersensitive narcissists showed a course of steady decline relative to how they had been functioning in their early 20s. Willful narcissists showed little change at 43 years of age relative to 21 years of age, after showing some growth in their late 20s. Autonomous, or healthy, narcissists, following conflict in their late 20s, experienced a surge of personality development by their early 40s, as indicated by satisfying intimate interpersonal relationships and career satisfaction and successes. Wink found that his group of hypersensitive (or covert) narcissists described their parental relationships as generally lacking warmth and reported feeling insecure in their relationship with their mothers. His willful (or overt) narcissists reported an attitude of dislike toward their mothers with concurrent pride in their fathers.

More recently, Russ, Shedler, Bradley, and Westen (2008) also found three subtypes among patients meeting criteria for NPD: (a) grandiose/malignant; (b) fragile; and (c) high functioning/exhibitionistic. Grandiose narcissists were described as angry, interpersonally manipulative, and lacking empathy and remorse; their grandiosity was seen as neither defensive nor compensatory. Fragile narcissists demonstrated grandiosity under threat (defensive grandiosity) and experienced feelings of inadequacy and anxiety, indicating that they vacillate between superiority and inferiority. High functioning narcissists were grandiose, competitive, attention seeking, and sexually provocative; they tended to show adaptive functioning and utilize their narcissistic traits to succeed.

In response to these findings and conceptual advances, Pincus and colleagues (2009) developed the Pathological Narcissism Inventory (PNI), a 52-item self-report questionnaire designed to assess both overt and covert aspects of pathological narcissism. In their initial validation study, they found that the PNI shows a robust 7-factor structure in large nonclinical samples, with factors corresponding to the following: Entitlement Rage (example item: "I get annoyed by people who are not interested in what I say or do"); Exploitativeness ("I can make anyone believe anything I want them to"); Grandiose Fantasy ("I often fantasize about being recognized for my accomplishments"); Self-Sacrificing Self-Enhancement ("I try to show what a good person I am through my sacrifices"); Contingent Self-Esteem ("It's hard for me to feel good about myself unless I know other people like me"); Hiding the Self ("When others get a glimpse of my needs, I feel anxious and ashamed"); and Devaluing ("When others don't meet my expectations, I often feel ashamed about what I wanted").

Later research (Tritt et al., 2010; Wright, Lukowitsky, Pincus, & Conroy, 2010) found that the PNI has a higher order, two-factor structure, with factors corresponding to narcissistic grandiosity and narcissistic vulnerability, and that this hierarchical factor structure is invariant across men and women (Wright et al., 2010). The initial validation study also found that the PNI subscales were related in theoretically consistent ways with patterns of interpersonal problems on the interpersonal circumplex and correlated with psychotherapy usage and suicidality (Pincus et al., 2009). Consistent with this finding, Tritt and colleagues (2010) found that the higher order vulnerability factor related to depressive temperament in a college sample.

### *Mental States*

Although a number of contemporary theorists and researchers have emphasized categorical distinctions among narcissistic individuals, many other clinical writers have increasingly stressed that grandiose mental states often oscillate or even co-occur with vulnerable mental states (Kernberg, 1975/1985; Kohut, 1971; Levy et al., 2007; 2011; Pincus & Lukowitsky, 2010; Reich, 1960; Ronningstam, 2011).

Building on the idea of narcissism as a defense against feeling vulnerable, Reich (1960) proposed that narcissistic individuals suffer from an inability to regulate their self-esteem. Importantly, she was the first to emphasize that these individuals "suffer regularly from repetitive, violent oscillations of self-esteem" (p. 224). She noted that they tend to lack integrated representations of self and others and that this deficit results in dramatic shifts from the heights of grandiosity to the depths of despair, self-incrimination, and intolerance for ambiguity—with few gradations in between.

Further, she noted that narcissistic individuals regularly inflate the importance of relatively minor activities and accomplishments while nonetheless remaining vulnerable to small slights from others, critical feedback, or outright failure, which sometimes causes them to react quickly with extreme despair. When feeling despair they may seek out others whom they can idealize or "bask in their glow," or if their perceived failure is large enough, they might plummet further into despair and even suicidality. Similar to their own vacillating sense of self, narcissistic individuals' sense of others dramatically shifts back and forth in an effort to shore up their own self-esteem. For narcissistic individuals, maintaining self-esteem is a delicate balance and shifts along this dimension may occur quite suddenly.

Rather than distinguishing between overt and covert types as discrete forms of narcissism, Kernberg (1992) noted that the overt and covert expressions of narcissism 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 clinical expression of overt and covert symptoms. Thus, the overtly narcissistic individual most frequently presents with grandiosity, exhibitionism, and entitlement but, in the face of failure or loss, these individuals may become depressed, depleted, and feel painfully inferior. The covertly narcissistic individual will often present as shy, timid, and inhibited, but upon closer contact, reveal exhibitionistic and grandiose fantasies.

Consistent with this idea, in a 6-month longitudinal study of 71 previously suicidal adults, Joiner and colleagues (2008) found that when people with narcissistic tendencies experienced depressive symptoms, they were prone to respond with increased levels of paranoia. Pincus and colleagues (Cain et al., 2008; Pincus et al., 2009; Pincus & Lukowitsky, 2010; Wright et al., 2010) now view narcissistic grandiosity and vulnerability as interrelated dimensions of pathological narcissism, and consistent with Kernberg's formulations, suggest that narcissistic patients are best differentiated from each other based on relative levels of grandiosity and vulnerability rather than by distinctions in categorical subtypes.

### *Dimensions and Levels*

Kernberg (1975/1985) classified narcissism along a dimension of severity from normal to pathological and distinguished among high-, middle-, and low-functioning pathological narcissists. At the highest level, patients are able to achieve the admiration necessary to gratify their grandiose needs. These patients may function successfully during their lifetime, but are susceptible to breakdowns with advancing age as their grandiose desires go unfulfilled. At the middle level, patients present with a grandiose sense of self and have little interest in true intimacy. At the lowest level, patients present with comorbid borderline personality traits. These patients' sense of self is generally more diffuse and less stable; they frequently oscillate between pathological grandiosity and suicidality. Finally, at the lowest or most severely narcissistic level, are those suffering with malignant narcissism. These patients are characterized by the typical symptoms of NPD; however, they also display antisocial behavior, tend toward paranoid features, and take pleasure in their aggression and sadism toward others. Kernberg contends that, despite the absence of depression, malignant narcissists are at high risk for suicide because such behavior represents sadistic control over others, a dismissal of a denigrated world, or a display of mastery over death.

### *Relevant Outcome Literature*

Recommendations for psychotherapeutic management of patients suffering from NPD are primarily based on clinical experience and theoretical formulations. Clinical case studies illustrate that some patients with NPD can be treated successfully and others often fail to respond to treatment. Although there are a number of psychotherapy studies of patients with a specific personality disorder, personality disorders in general, or Axis I disorders that have included patients with NPDs, no randomized controlled treatment (RCT) studies on NPD exist (Levy et al., 2007). Moreover, the controlled studies that have included individuals with personality disorders are difficult to interpret because these studies have focused on mixed types of personality disorders, without specifying narcissistic cohorts.

## Case Illustration

### *Presenting Problem and Client Description*

Mrs. N. was referred by a friend of hers in the field to a colleague who referred her to me for treatment. Her chief complaints were feelings of chronic depression and diffuse anxiety. The colleague who referred her to me had also indicated that she was prone to angry outbursts, that on occasion resulted in having the police being called. These outbursts occurred in places of business, when traveling, with friends, family, lovers, and with neighbors.

Mrs. N was a tall, attractive, married woman in her mid-thirties with three children, who looked slightly younger than her chronological age. She was the older of two children. Growing up, her father was an extremely successful businessman who had left her with a substantial inheritance. He was a self-made man who was “all business,” hostile, and very derogating of her, and generally too busy for his children. After her father’s death, her mother remarried. Her mother was both physically absent and emotionally distant while Mrs. N was growing up; although she provided for basic and nonemotional needs, Mrs. N’s mother tended to use this support to coerce her children to do as she desired. This pattern of behavior continued into her children’s adulthood. Mrs. N’s mother often provided the patient with loans as much of her inheritance was in the form of stocks and currently unavailable. Moreover, Mrs. N had difficulty managing her money and often relied on her mother to organize her finances. In return, her mother often pressured Mrs. N about where to live, where the children should go to school, and other major decisions.

Despite her overt belief that she had superior intelligence and abilities, Mrs. N reported constant difficulties doing well in school and in sticking with any one of her multiple hobbies (e.g., horseback riding, acting, and singing). She generally blamed her parents for not encouraging her or helping her develop her talents. She perceived herself as having difficulty concentrating or at least following through on tasks. She felt easily bored or frustrated with whatever she was doing. Despite her difficulties with money, she tended to hire assistants to carry out the more mundane aspects of her work and hobbies (e.g., she hired someone to exercise her horse because she found doing so boring and an imposition). Her difficulties sticking with hobbies were sometimes made worse due to angry outbursts she would have with friends, colleagues, or others involved in these activities. She would frequently change her mind with regard to which hobbies were most important and how she wanted to invest her time and efforts. She once sold a horse she owned because she had not ridden it in years, and then a few days later bought another after she saw a new horse she admired. The result of these patterns was that as she entered her 30’s, she had not yet developed expertise in any one area nor did she have a stable sense of what she wanted to do with her life.

To gain the approval of her parents, she married a man who, while supportive of her and tolerant of her rages, was unable to provide sufficiently for the family, in part, because he was disproportionately responsible for the children and, in part, because he was probably identity diffuse himself. Her inheritance and support from her mother provided for the family and allowed both her and her husband to live comfortably but without steady career investments. She felt terribly put out by having children, found them to be quite a burden, and yet needed them as an excuse for not having invested in a career path or achieved tangible successes.

In addition to depressed mood and diffuse anxiety, the patient reported angry outbursts, significant alcohol and marijuana use, concerns about rapidly shifting interests, and unhappiness with the lack of success in her life. She was heavily involved with drinking and marijuana use. She felt considerably activated by routine situations and demands and saw the alcohol and drug use as ways of dampening her internal experience. She shared that her husband was concerned that she was too disconnected from the children and overly frustrated with them—frequently losing her temper with them over rather developmentally normal stresses. By all appearances, she was quite brittle and needed much support. In addition to her mother’s financial and logistical support, she had a housekeeper, gardener, au pair, and a number of babysitters to help her maintain the household and take care of the children. Additionally, her husband did not work regularly and was the primary caregiver who not only took care of the children’s emotional needs but also brought them to all their lessons.

At times Mrs. N believed that her children and “unsupportive” husband were responsible for her “not making it” or becoming famous, and she had frequent fantasies of leaving her family and “making it big.” She attended acting workshops and sang in a series of local bands, occasionally developing crushes on fellow actors or band members, particularly younger men. Sometimes these crushes resulted in affairs, sometimes in unrequited love relationships. She often fantasized about leaving her family and touring Europe with a younger man who would produce her music and help her achieve fame and fortune.

### *Case Formulation*

The case formulation for this patient was derived over a number of sessions using Kernberg's (1984) structural interview. This is a psychiatric interview designed to elicit information to make a differential diagnosis between those with personality disorders and those with neurotic level functioning (as well as those organized at a psychotic level). The diagnosis and case formulation are based on a synthesis of reported and observed clinical symptoms, inferred intrapsychic structures based on the content and organization of narrative data, and the quality of the therapeutic relationship as experienced by the interviewer. During the structural interview, the clinician obtains the following information: mental status, a complete symptom picture, the patient's current function, and the patient's sense of self and others. The structural interview is not only important in establishing a diagnosis and case formulation with personality disordered patients, but it is also useful in gathering information that can be shared with the patient when providing feedback and developing collaborative goals for psychotherapy.

From the data that emerged, it became clear that despite her complaints, Mrs. N did not meet criteria for any Axis I disorder. Although there were some somatic symptoms, she did not have any of the neurovegetative symptoms of depression, nor did she report feelings of worthlessness or excessive or inappropriate guilt or recurrent thoughts of death. She did report depressed mood and occasional loss of interest in activities but these states were variable, fleeting, and typically in response to a perceived interpersonal slight. In fact, rather than being anhedonic, she was particularly self-indulgent and pleasure seeking. Likewise, she did not meet criteria for dysthymia or depressive personality disorder, bipolar disorder, or an anxiety disorder.

Although at times she displayed elevated, expansive, and irritable moods, they never lasted at least a week (or even 4 days, as would be required for a hypomanic mood); instead, these symptoms tended to be quite labile, quickly vacillating with depressed mood states as is more characteristic of personality disorders (Henry et al., 2001; Koeingsberg et al., 2002). This pattern was chronic as opposed to being present in discrete episodes, as is the case with bipolar disorders. With regard to generalized anxiety disorder (GAD), her anxiety was diffuse, free-floating, and variable. Her anxiety was also imbued with irritability and impulsivity, and the GAD diagnosis was contradicted by a variable presence of anxiety and long periods of lack of any anxiety, even in the face of anxiety-provoking situations. Although she had described an occasional panic attack, she did not meet criteria for the disorder.

As she discussed her functioning, she described situation after situation in which she flew into rages and made outrageous verbal attacks on those she was close to as well as strangers she encountered. She would fly into rages against her parents, her husband, her children, the au pair, her auto mechanic, her singing and acting coaches, lovers, and countless others. No one was safe from her wrath. On the section in which patients are asked to describe themselves and others, consistent with Kernberg's theory, Mrs. N was able to provide a relatively intact and coherent, if grandiose, description of herself, whereas her descriptions of others were quite impoverished. In terms of NPD, she clearly displayed a pervasive pattern of grandiosity in her fantasy and behavior, a need for admiration, and described instances of clear lack of empathy for others.

Specific criteria is as follows: (a) she displayed a sense of self-importance that was exaggerated in terms of her achievements and talents and she certainly expected to be recognized as superior without commensurate achievements; (b) she described being preoccupied with fantasies of unlimited success, power, beauty, and ideal love; (c) she indicated that she considered herself to be special and should associate with other special or high-status people; (d) she described a clear need for excessive admiration; (e) she displayed a sense of entitlement; (f) she periodically was interpersonally exploitive; (g) she had difficulty recognizing feelings and needs of others; (h) she was often envious of others and believed that others were envious of her; and (i) at times she behaved or displayed an arrogant, haughty attitude.

Based on her symptom picture, her functioning in work and love, and inferred psychological organization based on the quality of the narrative descriptions of self and others as well as the quality of her relatedness to others, it was felt that the panoply of symptoms she presented with could best be understood as occurring in the context of a narcissistic personality disorder diagnosis. This is a woman who aggressively defended against feeling small and inconsequential

to her parents, of whom one was hostile and derogating and the other was cold and disengaged. Understandably, she deeply wanted to be with her parents, to be valued by them, and to be nurtured by them. She was angry with them and others, sensitive to any indication that she was being devalued, and prone to distort benign situations so as to feel belittled. In these situations she quickly responded with extreme rage that often resulted in her being removed from a situation and/or the dissolution of previously established relationships.

I began working with Mrs. N using a version of transference-focused psychotherapy (TFP; Clarkin et al., 2006) that was specifically modified for work with NPD. TFP is an empirically supported treatment for borderline personality disorder, a “near neighbor” disorder. This choice seems warranted due to the high level of comorbidity between BPD and NPD as well as the theoretical connection between NPD and BPD (Kernberg, 1975/1985). Additionally, there is some preliminary evidence that TFP is uniquely efficacious when compared with dialectical behavior therapy and a supportive psychotherapy for narcissistic patients (Diamond, Yeomans, Stern, Levy, Hörz, Delaney, in press). Nevertheless, in recent years a number of technical modifications of TFP have been made to accommodate differences in the pathology between these disorders (e.g., Diamond & Yeomans, 2008; Diamond, Yeomans, & Levy, 2011; Diamond et al., in press; Stern, Yeomans, & Diamond, in press). These technical modifications will be described below.

### *Course of Treatment*

I could tell from the onset that I was about to begin a challenging treatment. Mrs. N’s opening volley to me showed both her aggression and her neediness. The very first thing she said to me, referring to my office, was “Gee, this is the nicest broom closet I have ever seen,” which was quickly followed by reprimands for a series of perceived failures on my part: I had no water cooler in my faculty office, my office was too far from where she had to park, the weather did not suit her. Each of these comments was embedded in an angry “put-out” affect and resulted in my feeling both criticized and sad. She was hostile, but I hypothesized that part of her wanted me to care for her. She wanted me to provide nourishment, intimacy, and atmospheric comfort. And even before I said anything more than, “Hello, please come in,” she was angry at me for wanting these things from me.

Immediately, I had a sense of the link between her neediness and her feelings of abandonment with her aggressiveness and superiority. I felt she wanted these things from me and she was sad that I could not provide them, but she was also angry at me that I had not provided them and that I evoked such desire in her. I also sensed that she took great pleasure in knowing that I was incapable of making a water cooler appear or of moving the parking garage. And, even if I could get her some water and find her a closer parking spot, I could not change the weather. Thus, it was me who was incapable, not her.

This dynamic continued, for as I explained my practice to her, she dismissed everything I said as if I was telling her things she already knew (despite the fact that this was her first therapy). When I told her my fee, she told me that I “would never get rich charging so little.” She followed this comment with stories of all the people who wanted a piece of her financially, as if she was made of money and others were corrupt users who wanted nothing more than to have what was rightfully hers. Infused in these comments were my presumed greed (i.e., that I was using her for my financial gain) but also its opposite: that I was not charging as much as I could and, therefore, maybe I was not a greedy money-hungry user. Additionally, she was scoffing at my fee as if it was inconsequential to someone with her money but at the same time expressing her concern that I didn’t really care about her besides the money. Early on, it was clear that her communications were complicated and represented a condensation of overt and covert narcissistic concerns.

Despite my experience of the patient as critical of me, she also spoke very glowingly about me and it became apparent that her experience of me was very different from the way she talked to me. Mrs. N described multiple situations in which she was hostile, disparaging, and rude toward others and I experienced her as that way toward me, despite the intermittent idealizations. However, she saw herself as someone others attacked, derogated, coerced, imposed upon, and

controlled. She could not acknowledge it but it seemed to me from her affect and the content of what she was saying that she found my questions and me a terrible imposition. Someone was being imposed upon and controlled and someone was imposing and controlling, but it was unclear to her who had what roles. She and I in the consultation room and others outside it vacillated back and forth in her scenarios.

As we continued the structural interview and I gathered information about her relationships and experience of others, she frequently talked about people in her life that she thought were narcissists or had a personality disorder. She often spoke to me as if we were colleagues discussing her family members who were "our" patients. I began to experience dread about sharing my diagnostic impressions with her. I fretted about how she was going to take it; I imagined that she might lash out at me and end the treatment (part fear, part wish upon reflection). This was an unusual feeling for me. I not only am an advocate of sharing diagnoses with patients but also usually feel quite at ease and skilled when doing so. Although it can be difficult to share a personality disorder diagnosis with patients, it is important that clinicians convey diagnostic impressions in order to collaboratively set the treatment frame.

Despite my apprehension, I knew what I needed to do and dutifully did so. I did my best to be tactful and precise in my language and to utilize the material she shared in ways that I thought would resonate with her. To my surprise, she took the news very well. My descriptions of her experience and the psychological rationales I described resonated with her; but, most importantly, despite her disparagement of those she perceived as narcissistic in her circle of family and friends, she disclosed that she had long suspected that she herself was diagnosable for NPD (in fact, she reported that she wondered about this for almost 10 years!). This was an important moment of both reflection and connection between us. We had a shared experience that I could now refer back to as needed. It was not just me who thought she was narcissistic; she too believed this.

The discussion of the treatment frame was easier now that we were both on the same page about the problems, and we discussed each of our roles and responsibilities in the treatment as well as the rationale behind them. Although she was less defensive, I knew that this state was only temporary. When working with personality-disordered patients, it is important to have a clear discussion of the treatment frame, or what is called the treatment contract in a TFP model. The contract-setting phase has multiple purposes. First, it educates the patient to psychotherapy. This is important for both the therapy-naïve and the therapy-experienced patient because even those who have been in multiple treatments may have only minimal understanding of this particular type of therapy, in part, because they may have been in therapies (e.g., supportive treatment, medication management, or cognitive-behavioral therapy) that utilized very different stances.

A second goal of the contract-setting phase is to establish a clear treatment frame that allows the patient and therapist to address and reflect on the material that arises in treatment, including feelings both in and out of session. The treatment contract creates a safe environment for patients, which allows their dynamics to unfold with the therapist. By providing structure and clear expectations, it also provides a safe environment for the therapist to work within. Having an explicit agreement of the tasks and responsibilities of each party also provides an avenue for discussing and understanding deviations from the frame or contract.

As Diamond et al. (in press) outline more fully, the contract-setting phase is more difficult with narcissistic patients because the expectations and responsibilities confront and limit the patient's grandiosity and omnipotent control and often results in their perceiving the therapist as controlling and imposing. The frame or contract is often initially rejected or tested in ways that may threaten the treatment. It is important when setting the treatment frame with personality-disordered patients that the therapist utilizes patients' past treatment experiences and relationship patterns to predict the kind of difficulties they might experience in the treatment. It is also important for the therapist to examine patients' responses to the treatment frame to ensure that they are not simply acquiescing to the goals proposed by the therapist but also making a true commitment. With Mrs. N, as I stated, although she felt what I was suggesting was reasonable at the moment, we might predict that at some later time she might feel differently and that it would be important to discuss those feelings as they arise.

It is not uncommon for NPD patients to begin therapy with either a haughty devaluing attitude toward the therapist or conversely with an idealization of the therapist as one who can magically provide solutions to all problems. Both these stances result from the need to sustain the grandiose sense of self and from the envy the patient experiences in relation to others. In both cases, the patient envies the therapist's functioning and psychological health. This conflict often leads the patient to devalue the therapist or aspects of the therapy and either subtly or explicitly reject the therapist's interventions. In Mrs. N's case, she prefaced every acceptance of what I offered with "of course." At other times, she made small tweaks to my wording. At still other times, she would reject what I said, only to come in the next week or some time later and share with me her newfound understanding which reflected exactly what I had offered earlier but which she had rejected.

One important technique when working with narcissistic patients is to work outside the transference, that is, to discuss the patterns of patients' relationships outside the therapy setting. These interpretations can have great immediacy and impact for the patient, and although they have been looked down upon within traditional psychoanalysis, they are consistent with the widening scope model (Bender, 2012). Another useful intervention with this population is to use "analyst-centered" rather than patient-centered interpretations (Steiner, 1994; Stern, Yeomans, & Diamond, in press). This type of interpretation focuses on the patient's experience of the therapist, typically in that moment, and is considered analyst- or therapist-focused because it stops short of interpreting the patient's motives to see the therapist in a particular way. Instead, the therapist allows the patient to hold this view of him or her without immediately challenging it, facilitating the examination of the patient's experience of the therapist more deeply and thoroughly.

Although these extratransferential and therapist-centered interpretations with a focus on the patient's affective experience are ideally experienced by patients as validating, they should not be delivered in a way that reinforces patient distortions. This is accomplished by maintaining technical neutrality and attending carefully to one's word choices and paralinguistic communication. From this nonjudgmental stance, therapists comment on patients' experience as a representation rather than treating it as actual reality; over time, therapists introduce alternate perspectives that facilitate a more integrative sense of self and other. For example, a therapist might say: "When I asked about X, you experienced me as attacking you, rather than seeing me as concerned." The value of providing such validation while simultaneously providing an alternative perspective in a gentle and matter-of-fact way is that it invites reflection in a nonthreatening manner and provides a base from which to build deeper understandings of the patient's experience. In this way, a therapist-centered interpretation, like extratransferential work, is preparation for a later transference analysis and transference interpretations.

These techniques were central to my work with Mrs. N. One theme that presented itself repeatedly was her sense that her various doctors and assorted helpers were not providing relief but instead making her worse. Over the course of weeks, she described how the various ministrations of her trainer, masseuse, chiropractor, and dentist left her feeling in pain. This led to discussions about whether she might be feeling the same about our work—that although she recognized that she was "getting better," including experiencing more satisfying family relationships, she might also feel that there was a terribly painful downside to therapy. Over time, she found it more tolerable to discuss our relationship and possible distortions of it. This led to deeper discussion about whether the work we were doing and the improvements she was experiencing were worth the effort, especially given her continued feeling that I was imposing my expectations on her.

Another turning point in the therapy came after I charged her for a missed session. The first few sessions after she received the bill were unremarkable, but a few weeks later she brought up how angry she was that I would charge her for a missed session. She reminded me that she had been up late the night before performing at a local venue and had overslept. We explored how she had held this feeling for a few sessions and the reasons why she might not have told me right away. It became clear that she wanted to protect me from her wrath and only weeks later could she even broach the subject without flying into a rage. We discussed her need to protect me and her fear that I might cower or be destroyed or abandon her. The fact that I could tolerate her

anger, discuss it openly, and not retaliate was important to helping her integrate her own feelings into a productive discussion. I modeled maintaining a thinking stance in the context of an affect storm. We discussed how part of her worried about my motivations and if I was only interested in her money. I wondered aloud if one could be interested in being compensated for one's time but also concerned about and wanting to be helpful to another.

The main vehicle for change in the treatment was being vigilant for indications of mental shifts that provided momentary windows into Mrs. N's more reflective, nondefensive spaces. The occurrence of these shifts between grandiose self-states and depressed, defeated, and vulnerable states are difficult to predict. Nonetheless, these are highly valuable opportunities and the therapist must be vigilant for them and seize these moments. With Mrs. N, these moments came frequently and we developed a shared responsibility for noticing their occurrence and reflecting and exploring them. As we explored them in the context of her discussions of others, she gained more awareness of when she was having this experience in relation to me and became more tolerant for our examining her experience of me not as truths but as representations of me that might include distortions similar to the ones she had about others in her life.

One issue that the therapist needs to be prepared for as the NPD patient improves is the true feelings of depression that arise with a more integrated experience and a greater capacity to take responsibility for one's behavior and mistakes. As Mrs. N improved, she began to feel closer to her husband and children. She increasingly described more satisfying interactions with her children and delighted in their genuine appreciation of her. She began to be more attracted to her husband, ended affairs, and lost interest in potential other relationships. She also became more forgiving toward her parents, recognizing that they did the best they could and that they had experienced difficult childhoods themselves. She also recognized that, despite their shortcomings, they wanted the best for her and her sibling. However, she also began to feel very depressed and even guilty about missed opportunities with her family and her past behavior toward them. This represented a new stage in the treatment.

### *Outcome and Prognosis*

Over the course of treatment, Mrs. N made a number of tangible and clinically significant improvements. These included marked decreases in frequency and intensity of angry outbursts, alcohol and marijuana use, and feelings of detachment from her family. In addition to these changes, she showed a marked increase in her tolerance for distressing thoughts and feelings, motivation to work and capacity for ordinary functioning, and time spent with her children and husband.

In sum, Mrs. N is now more productive at work, getting along better with co-workers, happier and more engaged with her children and husband, and happier in general. She is drinking socially and not smoking marijuana. Although she still feels tension quite often, she nonetheless is in much better behavioral control and only rarely loses her temper. Her internal experience of herself and others still is inconsistent at times and she is not completely free from symptoms of NPD. However, she is on the path toward more stable, realistic, and positive experiences of herself and others, and her prognosis is much better than when she entered treatment.

### *Clinical Practices and Summary*

This case illustrates a number of important aspects of psychotherapeutic work with narcissistic patients. Several suggestions follow:

- Obtain a thorough symptom picture to make a differential diagnoses and establish the presence of NPD or NPD traits. Many patients with significant narcissism or NPD present with multiple symptoms and find themselves being treated with medication or in short-term symptom-focused therapies or supportive therapies that do not address the underlying personality pathology. Although there is very little research on the treatment of NPD, the literature that exists is clear that NPD (or even NPD traits) increases the likelihood of dropout and may slow symptom change (Campbell, Waller, & Pistrang, 2009; Ellison, Levy, Cain, & Pincus, in

press; Hilsenroth et al., 1998). Thus, there is clinical utility in accurately identifying NPD or NPD traits.

- Assess both grandiose and vulnerable aspects of narcissism in patients and the pattern of oscillation.
- Recognize that patients with NPD or high levels of narcissism typically show significant impediments to beginning treatment and engaging fully in the treatment. They may begin treatment with unmodulated and unnerving idealizations or haughty, devaluating attitudes. Both can be difficult for the therapist to tolerate. They may also vacillate quickly between idealizations and devaluations, leaving the therapist feeling confused and deskilled. Therapists have to be on guard not to overinterpret these behaviors or respond defensively, aggressively, or collude with the pathology through passivity. Avoiding these problematic reactions can be facilitated by the therapist's maintaining his or her own reflective stance as well as through involvement in some form of supervision or consultation. The empirical literature for borderline personality disorder is probably relevant for NPD, particularly the finding that all empirically supported treatments for BPD include structured supervision to avoid therapist burnout and counterproductive reactions.
- Share diagnostic impressions with the patient in an effort to develop a collaborative set of treatment goals. It is difficult to develop collaborative goals if the patient thinks he or she has a depressive disorder and the therapist thinks the patient has a personality disorder but is reluctant to share that information. Having a diagnostic understanding of their problems allows patients to better understand the rationale for the treatment approach and facilitates reflection on their symptomatology and the therapeutic process.
- Consider implementing some of the following technical modifications and clinical stances:
  - A nonjudgmental and inquisitive stance toward the patient's difficulties and his or her perception of others, particularly the therapist.
  - An awareness of the greater-than-usual importance of tact and timing of interventions as well as precision in the use of language. Here, I am reminded of Jesse Geller's comment that therapeutic tact is the capacity to tell patients something they don't want to hear in a manner in which they can hear it. This ideal can be difficult to achieve with NPD patients, but the more sure you are that your word choice was precise and tactful, the more confident you can be that the patient's reaction represents a distortion. Poor word choice implicitly licenses the patient's reaction and may only serve to confirm his or her perceptions.
  - Use preparatory or preinterpretation comments. I find it helps to use the patient's words or preface interventions with comments such as "As you said earlier" so that he or she can more readily accept interventions.
  - Focus on relationships outside the therapeutic dyad, which often allows narcissistic patients room to explore the contents of their mind in a nondefensive, reflective, and thorough way. It may also allow for richer elaborations of the patient's internal experience than might be possible when her or she is talking about the same themes in the here-and-now of the treatment relationship.
  - Pay attention to negative transference. If left unaddressed, this material poses a serious risk and threat to the treatment. The need to allow, even encourage, patients to discuss their negative perceptions of their therapists ultimately allows them to better tolerate their own aggression toward themselves.
  - Develop a shared language. While this is important in all therapies, it may well be even more important with narcissistic patients given their proclivity to dismiss and reject the therapist's offerings. The use of a shared vocabulary can gently facilitate connection and ease acceptance of the therapist's comments.
  - Be vigilant for indications of mental state shifts that provide momentary windows into the more reflective, nondefensive spaces in the patient's mind. The recognition of these shifts represents highly valuable opportunities and the therapist must be vigilant for them.
  - Focus on preparing narcissistic patients for feelings they may have between sessions. Therapists should let these patients know that they may find themselves upset or angry (with the therapist) between sessions, and that such feelings are important indicators for the

treatment and can be brought up the next session. It can be useful to “prep” the patient after a difficult session or even a session in which increased awareness (including of closeness to the therapist) might lead to feeling upset or vulnerable between sessions.

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