Chapter 38

PSYCHODYNAMIC PSYCHOTHERAPY FOR NARCISSISTIC PERSONALITY

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Narcissistic disorders are prevalent and believed to be among the most difficult clinical problems to treat (Doidge, Simon, Brauer, Grant, & First, 2002; Gabbard, 2009; Kernberg, 1998, 2007; Kohut, 1971, 1977, 1984; Westen, 1997). Further, patients with narcissistic disorders can engender powerful countertransferential feelings of being incompetent, bored, derogated, disparaged, and dismissed (Diamond & Yeomans, 2008; Gabbard, 2009; Kernberg, 1986, 2007; Lachmann, 1994; Levy et al., 2007), or massively and unnervingly idealized (Kohut, 1971, 1977; Lachmann, 1994). With regard to the difficulty in treating NPD patients, Doidge and colleagues (Doidge et al., 2002) found that the majority of the NPD patients had sought previous short-term treatments, which were unsuccessful.

In this chapter, we present a psychodynamic framework for conceptualizing and treating individuals diagnosed with narcissistic personality disorder (NPD) or with significant narcissistic features. Narcissism encompasses normative strivings for perfection, mastery, and wholeness as well as pathological distortions of these strivings. Such pathological distortions may present overtly in the form of grandiosity, exploitation of others, retreat to omnipotence, or denial of dependency, or covertly in the form of self-effacement, inhibition, and chronic, extreme narcissistic vulnerability (Kernberg, 1975; Kohut, 1971, 1977; Ronningstam, 2009; Wink, 1997). Compounding the difficulties in diagnosing and treating narcissistic disorders is that they can manifest themselves in multiple presentations depending on the level of personality organization, subtype, or activated mental state. In this chapter we describe a specific clinical formulation of narcissistic pathology and how a particular manualized psychoanalytically oriented psychotherapy, Transference-Focused Psychotherapy (TFP) based on object relations theory, has been designed to treat patients with more severe narcissistic personality disorders; that is, those organized at the borderline level. In so doing, we review therapeutic modifications that can help clinicians effectively treat patients with narcissistic pathology at all levels of personality organization, and describe distinctions in levels of narcissism that influence how to approach both treatment and prognosis.

LEVELS OF NARCISSISM

Turning to questions of clinical assessment and treatment, we start by describing a gradation of levels of narcissism. *Healthy narcissism* is characterized by an integrated self that reflects awareness and acceptance of one's strengths and weaknesses. We define the self as a constellation of self and object representations, which in the normative situation are well integrated (that is, combine positive and negative aspects) and well differentiated (that is, self-images are separated from object images), allowing for a stable, overarching sense of identity (Kernberg, 2010). Such an integrated sense of identity based on a cohesive self allows for the regulation of self-esteem regardless of the vicissitudes of life and relationships, and such self-esteem

regulation is also related to a coherent and relatively individualized set of values and beliefs (Kernberg, 1984). Healthy narcissism allows for satisfying relations with others and allows for satisfaction in terms of work, ambition, and creative expression, for the ability to satisfy one's needs and desires without undue conflict and anxiety, and for the capacity to live in relative harmony with one's principles and moral values. In contrast from an object relations point of view, which has been developed by Kernberg (1975, 1998, 2010), pathological narcissism spans a spectrum of pathology from neurotic to borderline levels of organization. Characteristic of all levels of narcissism is the grandiose self, a compensatory structure in which realistic representations of self are combined with ideal self and object representations, and in which devalued aspects of self are projected onto others. Such systematic devaluation of others interferes with internalization of relations with others, leading to difficulties with dependency and with giving and receiving love and nurturance, limiting involvements with others including the therapist.

Narcissism at a neurotic level is characterized by a psychological organization in which there is a generally integrated sense of self, although these individuals show excessive need for admiration from others, attitudes of entitlement and exploitativeness toward others, lack of empathy, and excessive envy. Sometimes such neurotic level narcissistic patients may have made a good enough adjustment and are able to garner adequate self-esteem from a relatively stable grandiose self and tend to only seek treatment for transient symptoms. Individuals with this pathology demonstrate a good superficial adaptation, but their subjective experience ranges from depletion to elation. The grandiose self-organization limits their capacity for interpersonal relations in depth, making it difficult for them to derive enduring gratification in love and sexual relations; and further their faulty superego, which is untempered by ideal self and object images that inflate the ego, means that their demanding internal standards are never met, with a consequent difficulty in finding satisfaction from their achievements. Interpersonal relations are marked by a need for the admiration they cannot achieve in themselves with a corresponding shallowness in their emotional investment in others. In such cases, it is usually extreme professional or personal failures—often the result of cumulative negative impact of their narcissism on others—that challenges the hegemony of the grandiose self.

Narcissism at the borderline level includes individuals who show the typical manifestations of narcissistic personality disorder—described above (Kernberg, 1998, 2007). In addition, these patients present with general lack of anxiety tolerance, lack of impulse control, severe reduction in subliminatory functions, shown in severe or chronic failure in the sphere of work, chronic failure in efforts to establish or maintain intimate love relations, and chronic rage reactions despite some defensive functions provided by the pathological grandiose self (Kernberg, 2007). These individuals show the rupture between idealized and devalued aspects of the self, but beyond such a simple fracture there is the condensation of highly idealized aspects of self with real aspects, with all negative aspects projected onto others who are then systematically devalued.

We have found that patients with more severe forms of narcissistic pathology are particularly difficult to treat and may have a more guarded prognosis than other personality disorders functioning on the borderline level (Kernberg, 2007; Stone, 1990). Narcissistic pathology in the context of borderline organization involves the attempt to defensively retreat from a fragmentation-prone, unintegrated state of self into a pathological grandiose self that is characterized by the denial of dependency and finding refuge in an imagined omnipotence, often through identification with negative, aggression-laden internal objects (Diamond & Yeomans, 2007; Steiner, 1993). The maintenance of this imaginary state has the rigidity that is characteristic of all character pathology and leads individuals with pathological narcissism to lead more and more restricted lives because the simple experience of contact with others is a challenge to their grandiosity. To the extent that others exist for this type of narcissist, they are the object of the projection of the same idealized and devalued representations that characterize the patient's sense of self. To the extent that narcissistic defenses achieve their goals, they protect the individual from a devalued bifurcated sense of self, but at the price of severely impoverished relations

with others. Others tend to be perceived as either an ideal object who is beyond reach or who is a devalued object.

Malignant narcissism is a more pathological form of the condition that is marked by (a) egosyntonic aggression, (b) intense paranoia, and (c) antisocial traits. For such individuals, the grandiose self is not only infiltrated with aggression, but also sustained through identification with a punitive, primitive, and powerful introject, which provides the illusion of triumph over pain, death, and limitations through relentless attacks on self and others. The need to triumph over the other can lead to negative therapeutic reactions where the patient may engage in self-destructive actions, even suicide, as a means of defeating the therapist (Kernberg, 1984, 2007, 2010).

These configurations of narcissism that have emerged from object relations formulations converge with the trend to conceptualize narcissism as a dimensional disorder with varying degrees of pathology of self and object relations, reflected in the drafts of the *DSM-5* (Ronningstam, 2009).

ELEMENTS OF TECHNIQUE

Treatment Indications and Contraindications

The multiple levels and manifold surface presentations of patients with narcissistic pathology pose particular challenges for treatment. Because of their polysymptomatic presentation these patients may be treated in short-term symptom-focused therapy, medication, or supportive therapy that does not address the underlying structure of the disorder. The proliferation of psychoanalytic theories of narcissism has also led to the proliferation of treatment approaches (Bach, 1985; Gabbard, 2009; Kohut, 1971, 1977), but the efficaciousness of most of these treatment approaches has not been systematically and empirically investigated. We summarize Kohut's theory of treatment of narcissistic pathology, and then provide a more comprehensive overview of Kernberg's theory of treatment, which forms the basis for the first manualized psychodynamic treatment for personality disorders, including narcissistic, called Transference Focused Psychotherapy (TFP).

Through his experiences of the various transference manifestations of narcissistic patients, Kohut (1966, 1971, 1977) conceptualized narcissistic pathology as arising from an arrest at one of three normative phases of infantile narcissism: (1) the grandiose self, a derivative of normative infantile exhibitionism, in which a parental self-object is engaged to mirror and confirm the infant's sense of omnipotence and perfection; (2) the alter ego or twinship, in which a parental self-object provides the child with the experience of essential alikeness to another; or (3) the idealized parent imago, in which the child projects his or her sense of global omnipotent perfection onto an idealized parental self-object with whom he or she seeks to merge. In Kohut's view, if the archaic needs for mirroring, twinship, and idealizing experiences are frustrated by unempathic responses of the self-objects (or analyst), archaic residues of unmodulated grandiosity, need for alikeness, and idealization will persist in the adult personality, rather than be gradually modulated and transmuted into structures and functions such as realistic ambitions, mature goals and values, and wisdom, which ensure self-esteem regulation. In psychoanalytic treatment of patients with narcissistic pathology, these archaic structures will be reactivated in transferences of the mirroring, twinship, and idealizing types. These transferences, which will be gradually resolved and transformed into stable mature narcissistic configurations if the analyst tolerates, accepts, and empathically reflects the patient's archaic infantile narcissistic needs for mirroring, idealizing, and twinship experiences (Kohut, 1971, 1977).

In sum, the self of the narcissistic patient, although structurally unintegrated and affectively impoverished by failed idealization and mirroring, is not fundamentally fragmented by splitting and other primitive and ego weakening defenses as is the case in Kernberg's formulation of narcissistic disorders. However, Glassman (1988a) in a series of empirical investigations using causal modeling as a way of empirically testing the competing claims of Kohut and Kernberg, found some support for both models. Glassman (1988b) concluded that Kohut's self-psychology may constitute a subset of Kernberg's broader ego psychology-object relations formulations.

At the Personality Disorders Institute (PDI) of the Weill Medical College of Cornell, we have developed a manualized psychodynamic psychotherapy called Transference Focused Psychotherapy (TFP) for severe personality disorders based on Kernberg's (1975, 1984) object relations formulations (Clarkin et al., 2006), as well as a manualized treatment for neurotic, or higher-level personality organization (Caligor et al., 2007). In this section we will focus on TFP for narcissistic patients in the borderline spectrum. Although clinical experience indicates that TFP for patients organized at the neurotic level of narcissistic pathology is effective, we have research data only on TFP for narcissistic patients with borderline organization. A comprehensive description of TFP and the empirical investigations demonstrating its efficacy can be found elsewhere (Clarkin et al., 2006; Clarkin et al., 2007; Levy et al., 2006; Yeomans & Diamond, 2010). There have now been a series of studies including two Randomized Clinical trials (RCT) demonstrating the efficacy of TFP (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Doering et al., 2010). Here we summarize the clinical approach and its modifications for patients with NPD/BPD.

TFP is a psychodynamic psychotherapy modified for patients with personality disorders organized at the borderline level. The central concept of TFP is that an individual's identity is built up from representations of self and other that are based on affectively charged interpersonal experiences. They are internalized in the course of early development, organizing the individual's perception of self and others. The combination of an internal representation of self and other linked by an intense affect is referred to as an *object relation dyad*. These dyads become the building blocks of identity, of sense of self and other. Early representations are images of self and other in a narrow and specific role characterized by a single affect (e.g., a fearfully submitting dependent in relation to angry powerful authority, or a grateful recipient of care in relation to loving nurturer). In normative development, an individual achieves a state of integrated identity in which the representations of self and other with sharply different emotional charges blend into richer and more realistic internal representations that have a range of characteristics and affects. For example, at a given moment the individual may be anxious about a sign that the other is neglecting him but is able to place this in the context of an awareness that, in spite of lapses, the other is generally reliable over time. This awareness helps the individual modulate his affect.

Individuals whose psychological structure does not achieve this state of integration remain organized at the borderline level, characterized by a fundamental internal split between representations of self and other that are idealized and imbued with pure loving affect and representations of self and other that are imbued with totally negative affects, such as anxiety, anger, and hatred. Classically borderline individuals shift rapidly between extremely positive and negative states in their appreciation of themselves and in their relations with others. Individuals with narcissistic PD, as we have seen, tend to seek refuge from contact with a negative, devalued sense of self by developing a grandiose self that provides a superficial, but fragile and unrealistic coherence to a fragmentation-prone psyche. The conscious narrative of the grandiose self allows the individual a sense of wholeness, but one that is fragile and brittle. In addition, the rigid organization around the pathological grandiose self distorts the capacity for mentalization, or the ability to comprehend behavior in terms of intentional mental states, for example, the varied thoughts, feelings, beliefs, and motivations of self and others (Fonagy, Gergely, Target, & Jurist, 2002) because, for the grandiose self, the narrative is already written. Patients with narcissistic pathology cannot decenter, or mentally detach, from the grandiose self and so it is almost impossible for them to comprehend that the grandiose self is a mental state among other mental states that characterize the self (Diamond, 2009; Diamond & Yeomans, 2007).

Problems arise when this retreat into the grandiose self is threatened either by internal affect states that do not fit with it or by elements of reality (e.g., rejection by a partner or friend, difficulties at work) that pose a challenge to it. These characteristics predispose the individual to the following types of transferences: (a) idealization of the therapist as embodying positive traits that are a projection of the patient's grandiose self. Since the idealized other is included in the patient's grandiosity, the other is not experienced as totally separate individual and hence

is valued only as long as the other is a complement to and aspect of the grandiose self. (b) Devaluation of the therapist, as harboring the negative traits and affects that the grandiose self defends against. This may include a dismissive indifference. (c) Intense envy of the therapist if the segment of idealized internal images shifts to being projected on the therapist, leaving the patient with a sense of being defective and inferior. (d) Dependency on the therapist's mirroring functions coupled with indifference to the therapist as a real person; (e) suspicion of the therapist, in narcissistic patients with antisocial features. These patients are either devoid of an internal sense of mutual attachment to others or defend against it and have a "dog eat dog" attitude that includes only the possibility of mutual exploitation (Kernberg, 1986, 2007, 2010).

These transferences can be reflected on as the therapist engages the patient in joint observation of what develops in the relationship between them. In this process, the therapist has the double role of (a) provisionally accepting the patient's projection of defended-against parts of the patient's self, and (b) acting as an outside observer engaging the patient to study what emerges between them. The interpretive process, involving clarification, confrontation, and interpretation per se, is described elsewhere (Caligor, Diamond, Yeomans, & Kernberg, 2009; Clarkin et al., 2006).

Narcissistic Resistances

These are based both on the need to support the grandiose self and on the related envy the narcissist experiences in relation to others. Patients may begin therapy with 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. In both cases, the patient secretly envies the therapist for having the capacity for concern and caring, which bespeaks a level of wholeness and integration when the patient feels empty, fragmented, and worthless internally. This leads to a paradoxical situation: In order to try to protect his or her self-esteem in the moment, the patient devalues and rejects the help that might benefit him or her in the long term, with short-term gratification winning out over long-term gain. A pattern develops where the patient subtly or explicitly rejects anything the therapist attempts to offer in terms of understanding (a somewhat more positive variant of this is the patient who rejects everything the therapist says but comes to the next session reporting the idea as if it were his own). In these cases, the therapeutic focus becomes this form of interaction with the therapist and an exploration of the dynamics behind it.

The defensive nature of the grandiose self leads to a high risk of patients dropping out of treatment. The fragility of the patient's self-esteem and the need to defend against attacks from harsh elements of their own internal world leave the patient acutely sensitive to any suggestion of criticism or disapproval. Therefore, the therapist's curiosity and inquiry about the patient's difficulties, if not carried out with therapeutic neutrality (Clarkin et al., 2006), could lead the patient to feel criticized and to end treatment.

We illustrate the above points by presenting the stages of TFP with case material. Introduction to the case:

Alfred, a 35-year-old single man, presented with the following complaint: "I've seen many therapists for anxiety and substance abuse and nothing helped. I'm still anxious and having difficulties at work. I'm attracted to women who fall in love with me, but these relationships never last. I know I'm really attractive and special and I can't understand why these relationships keep falling apart." He described his relationship with his father, an attorney who expected Alfred to follow in his footsteps, as pressuring but disengaged. His parents divorced when he was 8, and he was largely raised by his mother, a beautiful and talented woman who was extremely possessive and attempted to live vicariously through him, but who also neglected and envied him. She would parade Alfred around to her friends for admiration in social situations, but then would ignore him for long periods. Alfred's representation of his mother was overwhelmingly negative: "the sadistic sorceress" who did not want him to have an autonomous life, and who attempted to control his choices about career, friendships, and love relationships.

Nonetheless, Alfred graduated from a prestigious law school, and worked for several corporate firms, but had either left or been fired because of chronic interpersonal difficulties with supervisors. He sought treatment with Dr. S. 5 years after graduating from law school when his symptoms of substance abuse, anxiety, and passive suicidal feelings escalated in the midst of a work crisis after having been passed over for a promotion. He had also had several failed relationships with accomplished and attractive women whom he would pursue adamantly but then lose interest once he secured their love; or when his demands for exclusive attention and constant admiration became excessive they would end the relationship. Previously, Alfred had consulted with several well-known clinicians but had only lasted a month or two in any treatment. He described these therapists in contemptuous terms, stating that they did not understand him, were of no help, and only mirrored back to him what he already knew. Alfred was initially somewhat aloof and exploitative in his initial attitude toward the therapist, insisting that he wanted solutions for his immediate problems and did not want to get into a protracted treatment. In the initial consultations, however, Dr. S. suggested that a chronic pattern of fluctuation between overestimation of his capacities and importance and collapse into extreme vulnerability underlay his anxiety, difficulty with work and relationships, and substance abuse. Alfred readily agreed and stated that none of his previous therapists had understood the nature of his difficulties and that he believed Dr. S. was uniquely suited to treat him. Dr. S. formulated with the patient a treatment contract that stipulated twice-weekly therapy based on understanding the emotions behind his symptoms and dysfunctional behaviors. The contract also included a commitment to abstain from his intermittent substance abuse, and if he was not able to do so to attend AA or a harm reduction group, to commit to his current work situation until his motivations for wanting to leave had been more thoroughly explored, to agree to discuss any feelings about ending therapy before acting on them, and to report self-destructive behaviors and feelings and take responsibility for not acting on them. Initially, Alfred was resistant to the idea of a contract that would place any limitations on his behavior. This led Dr. S. to begin to interpret his noncollaborative and even exploitative stance toward others, which seemed related to so many of the disruptions in his life.

As seen in this example, the first stage of TFP is to create a treatment frame through the treatment contract that allows the patient's internal representations to unfold in the relationship with the therapist (Clarkin et al., 2006). The contract, which stipulates the roles and responsibilities of both patient and therapist and places limitations on the patient's destructive and self-destructive behaviors, often immediately activates the transference; that is, the transference of internal representations to the external relationship to the therapist. The patient is not immediately aware that the internal representations that are activated in the therapeutic context may not be an accurate representation of the actual relationship with the therapist. When this transference is activated through the contract setting process, it can constitute the first window into the object relational world of the patient, and thus may be observed and explored with the goal of helping the patient understand his internal world and the motivations for maintaining a system of perceptions and beliefs that does not correspond well to the surrounding world. With the narcissistic patient, contract setting is especially difficult because the setting of responsibilities confronts the grandiose self and hence is often initially rejected or tested.

The contract and frame are particularly important in cases where the patient's grandiosity has kept them from functioning autonomously; instead, such patients often receive significant secondary gain of illness in the form of assistance from family or the social service system. In addition, narcissistic patients often bend the rules in other aspects of their life, engaging in practices in work or professional life that aggrandize themselves, such as borrowing the work of others without adequate credit, falsifying results, or engaging in other forms of behavior based on feeling above the rules that apply to others. The discussion of the contract includes the concept that the patient's life activities, or lack thereof, are part of the treatment process. This is particularly important for more severely disturbed BPD/NPD patient, who may withdraw into a cocoon of isolation, often living a parasitic existence in which they exploit others in order to maintain their illusory self-image. Engaging in activities in the world is considered essential to therapy

because it serves the dual purposes of bringing to the surface some of the conflicts the patient may avoid through isolation, and providing the patient with the opportunity to discuss in session the anxieties evoked by interactions with others.

Defining the Dominant Object Relations

A central strategy of TFP is to articulate the internal object relation dyad that is activated in the transference at a given moment so that the patient will become aware of the internal scenarios that may affect his or her experience of the interpersonal world. The typical dominant dyad of the narcissistic patient is that of the omnipotent grandiose self and insignificant devalued other. The initial identification of this dyad for the narcissistic patient is especially difficult because of the anxiety associated with taking an observing distance from the grandiose devaluing part to explore other aspects of self (e.g., weakness, vulnerability, humiliation); the narcissist is everything or he collapses into nothing. Patients with covert narcissism, so-called *thin-skinned narcissists* (Rosenfeld, 1987) have a similar difficulty in distancing from the insignificant devalued part of the dyad, which defends against suppressed grandiose strivings. Hence clarification of the dominant affects and associated object relations, the first stage of the interpretive process, is difficult because the affects of humiliation, envy, and fear of dependency that devolve from the grandiose self are rigidly defended against.

To counter this, the therapist must work with "therapist-centered interpretations" designed to identify the predominant affects that the patient is experiencing in the moment to moment relationship with the therapist without yet making linkages to the grandiose/devaluing part of the activated object relational dyad, to the patient's defenses, or to his or her history (Caligor et al., 2007; Steiner, 1993). Thus, in so far as the patient is phobic of perceiving flaws in the self, one aspect of technique is to focus more on these negative feelings such as humiliation, weakness, or shame as they are projected onto the therapist, perceived as incompetent or inadequate. Such object-centered interpretations—therapist-centered interpretations—are important with patients who initially cannot tolerate seeing flaws in themselves but may be able to observe them in the therapist and reflect on what it is to have limitations without collapsing into worthlessness. Therapists may get derailed at this stage because of their attempt to be the perfect idealized object for the patient, rather than tolerating the patient's devaluation and understanding it as an aspect of the patient's internal world of representations and associated affects.

In the initial phases of therapy, Alfred filled sessions with immediate crises at work and in his relationships, often demanding answers to questions and solutions. Dr. S. pointed out that these demands reflected an idealization of her as an omniscient other who could magically fix his dilemmas. When it became clear that such magical answers were not forthcoming, a pattern developed in which Alfred would lecture Dr. S. about narcissism, based on what he had read, pointing out how what she did and said was very predictable. Alfred stated that he was "smarter" than her, that she was just tossing back things he had said, and that while he was going to give treatment a chance he did not believe that Dr. S. had anything to offer beyond a bunch of techniques he could read about. Dr. S. observed that Alfred's concern with extracting advice from her or making himself an expert to solve the immediate problem was keeping him in the superior position, but deprived her of any contribution she might make. Exploration of these dynamics led to the identification of an object relational scenario of a superior omniscient self with a devalued, inadequate other that the patient was now repeating in the transference, but without linking this to his narcissistic defenses (omnipotence), or to his history of being both neglected and exploited by his parents. With Alfred, as we have observed with other NPD patients, any attempt to point out that he was attacking Dr. S. as he attacks and undermines himself were dismissed as "what you learned in your books." The treatment at this phase thus focused on helping Alfred to focus on his myriad experiences of Dr. S., which in the first months often took the form of seeing her as flawed, inadequate, or unhelpful, and himself as the expert, since

his own sense of inadequacy and vulnerability was intolerable and his immediate need was that they continue to be contained by Dr. S., and understood primarily in their projected state (Caligor et al, 2007; Steiner, 1993).

Working With Role Reversals

Interpretation of role reversal in the transference is the next step of interpretation and is challenging with narcissistic patients because there is less oscillation of self-object dyads due to the rigid defensive nature of the grandiose self, which makes alternate relational scenarios more difficult to identify and reflect on. With borderline patients without severe narcissistic pathology, the dominant object relations are usually readily activated with the patient oscillating between identification with the self or object poles of the dyad in rapid succession in both extra-transferential and transference relationships: a patient may feel special and all-powerful at one moment and worthless and insignificant in the next. Work in the transference is also difficult with NPD/BPD patients because of their inability to even acknowledge or invest in a relation with the therapist. The therapeutic relationship may be eclipsed by the patient's investment in the grandiose self, which is identified with ideal internal self and object representations, with the therapist at times included in the patent's grandiosity and at other times excluded and devalued.

Because the grandiose self provides some measure of protection from rapid shifts in self-states, the predominant transferences of narcissistic patients can appear stable. However, patients with more severe narcissistic disorders are at the risk of a catastrophic shift to extreme distress if the defensive function of the grandiose self fails and the array of negative affects linked to negative images of the self breaks through, leading in extreme cases to suicidal and self destructiveness (Ronningstam, 2005; Ronningstam, 2009; Ronningstam, Weinberg, & Maltsberger, 2008). Therefore, the therapist must proceed with utmost tact in the early phase to help solidify the therapeutic alliance. And, as stated earlier, it is often easier to begin to interpret the patient's devaluation of the image of the therapist and then the distress (sometimes hidden beneath a superficial triumph) that accompanies it before addressing the devalued sense of self that the grandiose self defends against.

Alfred's initial response was to belittle Dr. S. for these interpretations to make her feel exposed and humiliated. He expressed resentment at having to take his valuable session time to talk about his relationship with Dr. S. when what he really needed was advice on how to find the perfect woman to commit to him, or how to advance at work. After some months of persisting in these interpretations and pointing out how he tries to wrest control of the treatment and incorporate Dr. S.'s insights as though they were his own, he responded, "You're right. I try to dazzle you with my intellect. It's too painful to talk about feelings about my inability to get promoted at work or find a committed relationship," a first indication of access to the fragility beneath the grandiose self. In subsequent sessions, his demands for immediate solutions increased and Dr. S. interpreted this as a reaction to his fear of having shown some vulnerability and even dependence on her. She also pointed out that his persistent requests for solutions reflected the pattern he repeated in all of his intimate relationships: to make unreasonable demands on the other and then drive them away.

Alfred became increasingly aware of the fluidity or instability of his identifications with each side of the dominant object relational dyad of superior, grandiose self and devalued other; however, his grandiosity and exploitativeness remained somewhat impervious to interpretation until this complementary relationship pattern was enacted around a crisis in paying the bill. Although he had good insurance, he had failed to file insurance forms for months, claiming that he was too busy. Dr. S. wondered, given how desperate he was about his work and relational life, why he was jeopardizing his therapy by not paying the bill. Alfred responded to this confrontation about his contradictory behaviors and attitudes toward treatment by stating that he expected special treatment from the therapist whom he believed should treat him pro bono.

In subsequent sessions when Dr. S. called attention to the somewhat dismissive tone of voice that Alfred used when talking about the bill, he stated, "now over 15 minutes of the session have gone by and you are imposing your agenda on me. You're like a mother—not my mother—but a mother telling me what I have to do." Dr. S. observed, "It sounds as though you are experiencing me as a demanding but neglectful maternal figure who imposes her agenda without taking into account your needs, and yourself as an angry, resentful child who has to do her bidding in order to win any love or affection." In addition, Dr. S. proposed that, without any awareness, Alfred might be the one who was imposing his agenda—to attend therapy without paying—and thus be enacting a reversal of the relationship. This led to an exploration of the patient's identification with a controlling and punitive maternal figure (the sadistic sorceress), who was being projected onto the therapist. Subsequently, Alfred became tearful for the first time and agreed to settle the bill. He then stated, "I see this (therapy) as a lab experiment to try to have a different kind of relationship. I don't want to drive her [his current girlfriend] away. I want to be healthy enough to try to have a relationship with her but already I feel that she wants to get away from me. I always ask for too much and I wind up with nothing." Dr. S. replied that he was talking about driving away his girlfriend but perhaps it was also Dr. S. that he feared driving away with his demands for perfect caregiving (e.g., not having to pay the bill). She also suggested that paying the bill would be to acknowledge his need for and dependence on her as well as the limitations of what she had to offer—thereby gaining access to the anger and vulnerability that were masked by the grandiose self.

Identifying Dissociation and Splitting Among the Dominant Object Relations: Analysis of the Grandiose Self

After focusing on the role reversals within the prominent dyad, the next step in interpretation involves bringing attention to the relationship between two object relations that have been defensively dissociated, addressing splitting between two polarized aspects of experience. This level of interpretation most often addresses the split between an aggressively charged object relation associated with frustration and hatred, and an idealized object relation, associated with gratification and nurturing. In narcissistic patients, the negative dyad is more typically that of the grandiose self in relation to the devalued other.

An alternative to this prison of grandiosity is a dyad of the self that is dependent on a concerned rather than grandiose other. This dyad may be present as just a trace in the internal world of narcissistic patients and is one reason that the therapist's early interventions tend to be therapist-centered and that confrontations may come more slowly in work with narcissistic patients: the very experience, in the therapy, of a concerned other who is not defensive or retaliatory is a confrontation of the "grandiose-devalued" dyad. The therapist's collaborative and exploratory, but neutral stance are both an implicit confrontation of a "superior-inferior" model of relating and an invitation to experience and reflect on a relationship that involves mutuality. As these issues are addressed, it becomes possible to interpret at the deepest level the anxieties that have maintained the retreat into grandiosity: anxieties of abandonment, insignificance, and even annihilation as the consequence of relinquishing grandiosity and allowing dependency and mutuality. Thus, the therapist challenges the dismissing attitude of the patient, and creates the context for a secure attachment relation to begin to emerge.

As Alfred began to acknowledge and work with his identification with both aspects of the grandiose controlling/submissive, subservient dyad, the dyad of dependent self-concerned, loving other emerged. He began coming early to sessions, sitting in the therapist's waiting room using the time to write in his journal. Dr. S. interpreted this behavior as an indication of Alfred's growing ability to tolerate dependency on her, and his journal writing as an identification with her and her reflective function. Previously, Alfred had been angry and contemptuous of Dr. S. because she could not guarantee a perfect job or relationship, and had disparaged her offering

him the more limited function of analyzing why he had not been able to fulfill his goals and desires, along with her empathy and concern. As Dr. S. repeatedly interpreted how Alfred's devaluation of her and what she had to offer was actually a split-off aspect of his own idealized self and objects, Alfred began to recognize how these projections protected him from the pain of facing his own and others' limitations, and made it impossible for him to experience pleasure and gratification in, as well as gratitude for what the therapist and others could realistically offer him. At work, his conflicts with his supervisor diminished and he received a promotion. In his personal life, he began to date a woman he referred to as a *good person*, whom he initially devalued because she didn't have the arrogant superiority that he had previously sought in women. This expression showed his difficulty in accepting genuine caring from an available as opposed to unattainable idealized other. However, over time he came to understand that his tendency to devalue anyone who genuinely loved and cared for him was in part a result of his identification with a maternal representation of 'the sadistic sorceress' now part of him as a powerful but punitive internal object that systematically undermined his own capacity to experience ordinary love or happiness, while at the same time fueling his sense of grandiosity and omnipotence. Such work in the transference involved the patient repeatedly projecting the devalued aspect of himself and the hated aspect of his objects onto the therapist in order to protect the grandiose self. It was through the therapist repeatedly pointing out the ways in which such projections preserved his fragile idealized self and objects and protected him from facing the pain of his own and others' limitations that allowed him to experience pleasure and gratification in what others could offer, that the grandiose self was gradually dismantled.

SUMMARY

We have presented an overview of a range of psychoanalytic object relations understandings of narcissistic pathology, with an emphasis on a form of psychodynamic psychotherapy, Transference Focused Psychotherapy (TFP), designed to treat personality disorders including NPD. We have described the defensive establishment of the compensatory grandiose self that is central to pathological narcissism and have identified distinctions in levels of narcissism that influence how to approach treatment and prognosis, We have also reviewed therapeutic modifications of TFP that help clinicians effectively treat patients with narcissistic pathology and have provided illustrative case material.

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