## CHAPTER 1

# Treating Pathological Narcissism with Transference-Focused Psychotherapy

## *An Introduction*



A high-functioning narcissistic patient began treatment by saying, "I didn't learn anything about myself that I didn't already know in my previous four years of therapy, and I expect that will be the same in this treatment . . . I just want someone to hold my hand while I decide whether I should end my relationship." After several years of outpatient treatment, another formerly highly suicidal patient said, "I'm better but I can't admit it because your success is my failure." Such statements taken from intensive and ultimately productive treatments highlight the formidable clinical challenges posed by narcissistic people across the spectrum of functioning from high functioning to more severely disturbed. High-functioning narcissistic patients may present as socially engaging, charming, and successful in politics, the arts, finance, or other fields, but their grandiose self-presentation often masks the underlying vulnerability to dysregulating states of fear, rage, and despair in the face of threats to self-esteem. By contrast, more disturbed narcissistic individuals may appear on the surface as anxious, submissive, shy, and self-defeating, often withdrawing from both intimate relating and occupational challenges to preserve their fragile and often hidden sense of specialness or uniqueness. Whether this self-pathology is expressed overtly in self-aggrandizing behavior or covertly in grandiose beliefs and fantasies that the individual may be too shame ridden to reveal, the patient's difficulties allowing for a healthy dependency upon and attachment to the therapist, as well as difficulties in tolerating interpretive work that challenges rigid defenses and invites reflection on inner

turmoil and distress, often secreted and unseen, pose significant technical challenges (Behary & Davis, 2015; Stone, 1989; Kernberg, 2007, 2018; Clemence, Perry, & Plakun, 2009; Diamond, Yeomans, & Levy, 2011; Gabbard & Crisp, 2018; Ronningstam, 2018). In therapy, many individuals with pathological narcissism present as self-aggrandizing, arrogant, entitled, exploitative, and unempathic, relentlessly devaluing others, yet craving the admiration of denigrated others, including the therapist. Paradoxically, others with the disorder appear as self-effacing, introverted, and inordinately vulnerable to rejection or criticism, particularly by the therapist, whom they tend to idealize. These contradictory patient profiles may tax the skills of even the most experienced clinicians, engendering powerful countertransferential responses of feeling incompetent, bored, or disparaged in the face of the patient's devaluation, or at the other extreme, being beguiled or even captivated by the experience of being massively and unnervingly idealized (Betan, Heim, Zittel Conklin, & Westen, 2005; Gabbard, 2009; Kernberg, 1975, 2007; Kohut, 1971, 1977). Indeed, the countertransference pressures that individuals with pathological narcissism may generate in their treaters often result in stalemates, enactments, premature or precipitous terminations, or the endless prolongation of treatments with little improvement.

Perhaps because of the daunting treatment challenges they pose, theorists from almost every major psychodynamic approach have written on the nature of pathological narcissism and/or narcissistic personality disorder (NPD). These approaches include *classical and contemporary Freudian* (Akhtar & Thompson, 1982; Cooper, 1998; Ellman, 2014; Gabbard & Crisp, 2018; Ronningstam, 2000, 2005, 2012, 2016), *Kleinian and neo-Kleinian* (Britton, 1989, 2004a; Feldman, 1997, 2007, 2009; Joseph, 1959, 1989), *self-psychology* (Kohut, 1971, 1977; Lachmann, 2007; Lichtenberg, 1988), *interpersonal* (Fiscalini, 1994), North American *object relations* (Bach, 1985; Kernberg, 1975, 1984, 2010, 2018), and the *relational school* (Bromberg, 1983; Cooper, 1998; Mitchell, 1986; Shaw, 2013). Interest in narcissism is now being generated among *cognitive-behavioral* clinicians (Behary & Davis, 2015; Behary & Dieckmann, 2011; Cukrowicz, Poindexter, & Joiner, 2011), as well as those who work in the framework of *attachment-* and *mentalization-based* treatments (Unruh & Drozek, 2020; Bateman & Fonagy, 2016). These divergent approaches to understanding narcissism and narcissistic pathology have fueled among the greatest controversies in psychodynamic thinking from Freud to the present. But while they may differ in theoretical and treatment approaches, the majority of clinicians and clinical researchers concur that the current DSM NPD categorical formulation, which emphasizes grandiose behaviors and attitudes, is inadequate to understand the complex dynamics of the broad spectrum of

patients who suffer from pathological narcissism and its often devastating consequences in their work and relational lives (Paris, 2014; Pincus, Cain, & Wright, 2014; Ronningstam, 2009, 2011, 2012, 2014, 2016; Wright, 2016). However, relatively few have translated their theories or research findings into systematic, empirically informed approaches to assessment and therapy that address the specific challenges posed by individuals with pathological narcissism.

In this book, we offer a conceptualization of narcissism, both normal and pathological, based on contemporary object relations theory. We begin with a detailed description of pathological narcissism and its underlying structure, providing clinical examples, as well as research findings from social cognition, attachment, and neurobiology in support of this model. We view pathological narcissism as a form of personality disturbance that may be present in individuals across a spectrum of functioning, from the cusp of neurotic to borderline to malignant narcissism, the most severe form of the disorder where patients are at the edge of treatability.

The concepts of pathological narcissism and NPD are often used interchangeably to refer to narcissistic pathology, and they overlap to some extent. *Pathological narcissism* refers to a broad range of conditions that include the more specific NPD. Rather than conceptualizing NPD as a categorical diagnosis, we offer a developmental dimensional model of pathological narcissism which exists at different levels of severity and can encompass diverse presentations (Aslinger, Manuck, Pilkonis, Simms, & Wright, 2018). This approach is consistent with transdiagnostic and dimensional models of psychopathology (Haslam, Holland, & Kuppens, 2012; Sharp & Wall, 2021). Individuals with pathological narcissism may present with an array of varied and sometimes incongruent symptoms, and show a range of disparate characterological features from grandiose to vulnerable; from self-aggrandizing to self-effacing; from socially dominant to socially withdrawn; from histrionic or self-dramatizing to masochistic or self-defeating; and from depressive and excessively self-critical to callous, dishonest, and even antisocial. Furthermore, pathological narcissism encompasses patients who function at a different level of personality organization (e.g., neurotic, borderline, and psychotic, as described below). In our view, the terms *pathological narcissism* and *narcissistic personality disorder* go beyond the narrow DSM-5 descriptive criteria that privilege the overt attitudes and behaviors associated with grandiosity (e.g., exaggerated sense of self-importance, exploitative behaviors, lack of empathy; American Psychiatric Association, 2013). These criteria have allowed for standardized assessments for research purposes, and some of the research studies in this book are based on clinical and nonclinical groups with

DSM NPD diagnostic criteria, while others are based on those with narcissistic traits. Our object relations conceptualization of pathological narcissism encompasses DSM descriptive criteria as only one presentation of a multifaceted or pleomorphic (Gabbard & Crisp, 2018) disorder. What unites these conditions are core structural features, most notably a pathological grandiose self-structure: a specific configuration of internalized, idealized representations of self and others (described below), of which the disparate descriptive criteria that characterize the disorder are but the surface manifestations.

The focus of this book is on how the object relations model, which postulates certain core structural features of the disorder, has been translated into a therapeutic approach applicable to a broad spectrum of narcissistic patients. The development of such treatment approaches is crucial, since it is increasingly recognized that NPD represents "a disabling and major public health problem in its own right" (Pulay, Goldstein, & Grant, 2011, p. 167). NPD is associated, as are all personality disorders, with clinically significant distress and functional impairment in the areas of occupational performance and interpersonal relationships, particularly intimate or couple relationships (Grant et al., 2004). Individuals with NPD now comprise 1.3–17.0% of clinical groups (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Ronningstam, 2009) and 8.5–20.0% of patients seen in outpatient practice (Zimmerman, Rothschild, & Chelminski, 2005; Bodlund, Ekselius, & Lindström, 1993). The prevalence of NPD may be particularly high in outpatient private practice. In several independent surveys 30.0–76.0% of clinicians reported treating narcissistic patients (Westen & Arkowitz-Westen, 1998; Doidge et al., 2002; DiGiuseppe, Robin, Szeszko, & Primavera, 1995).

Narcissistic traits, if not a full NPD diagnosis, appear to be on the rise in the general nonclinical population, particularly among adolescents and young adults. According to one study, the level of narcissism among American university students (as assessed by self-report measure, the Narcissistic Personality Inventory [NPI]; Raskin & Hall, 1981) has been escalating since 1980 with an elevated level of specialness and entitlement comparable to that of celebrities (Foster, Campbell, & Twenge, 2003; Twenge, Konrath, Foster, Campbell, & Bushman, 2008b; Twenge, Miller, & Campbell, 2014). In a community study, young adults in their 20s were found to have three times the rate of NPD as were those over 65 (Stinson et al., 2008). Narcissism, as a construct with meaning beyond the consulting room, has entered our social and political discourse in unprecedented levels since 1979, when social theorist Christopher Lasch (1979) first described our society as a "culture of narcissism." More recent investigations by social psychologists have identified a "narcissism epidemic" based on a systematic rise in narcissistic traits among college students over the past 3 decades. These traits include unrealistically

inflated self-esteem, entitled expectations about careers, investment in self-development over connection to others, and indifference to the welfare of others (Foster et al., 2003; Twenge, Konrath, Foster, Campbell, & Bushman, 2008a, 2008b). Psychoanalysts, such as Aaron Stern (1979), have noted an intensification of conflict in young adult patients between the opportunities for an exaggerated sense of self-enhancement and self-adulation offered by a narcissistic culture, and the need for interdependence and mutuality that inevitably puts restraints on the pursuit of gratification of narcissistic needs. These findings invite further dialogue between social theorists and practicing clinicians.

Sociocultural trends, including the culture of competitive individualism, the breakdown of extended family structures that leave the individual unmoored without deep and enduring kin networks, and the lure of social media as a vehicle for both self-aggrandizement and transient, superficial connections with others, may promote narcissistic traits in the general population. The ubiquitous use of tweeting, texting, Instagram, Facebook, and reality TV fosters self-promotion and self-aggrandizement, along with instant, if distal, access to others, leading to superficial, often transient and shallow, encounters. Face-to-face communication that might encourage deeper and more enduring levels of intimacy is curtailed; both self and relationships are constructed and conducted on the proscenium of social media. These social trends have set the stage for a new cultural experience of self, offering unprecedented opportunities for self-aggrandizement; promotion of inflated, magnified, or distorted self-images; and ephemeral connections with others on the one hand (Twenge & Campbell, 2009), but also a multiplicity of opportunities for self-definition and self-expression on the other (Blatt, 1983; Diamond, 2006). While there is clearly a continuum between dominant personality traits and forms of psychopathology of a given era, between individual and collective narcissism, the precise relationship between the rise of narcissistic traits in the nonclinical population and the development of clinically significant pathological narcissism or NPD, which involves a specific structuring of the personality, remains in question. Indeed, a recent study has shown a decrease in the characteristics of vanity, entitlement, and leadership among college students (Wetzel et al., 2017), even while rates of narcissistic pathology appear to be on the rise among clinical groups (now from 1.3 to 17.0% of outpatients; Clarkin et al., 2007; Zimmerman et al., 2005; Ronningstam, 2018). Thus, it has become increasingly important to define the contours of pathological narcissism as a clinical diagnosis; identify its continuities and discontinuities with narcissistic traits in the general, nonclinical population (Diamond, 2006; Paris, 2014; Perry, 2014; Kealy & Ogrodniczuk, 2014); and develop approaches to assess and treat narcissistic pathology, which involves a specific maladaptive structuring of the personality.

## Narcissism: Normal (Adaptive) and Pathological

Narcissism is a core psychological construct, and perhaps one of the most ubiquitous and perplexing because it may take both normal and pathological forms. From a traditional psychoanalytical perspective, narcissism involves investment in the self of both positive, loving feelings or libido (Freud, 1914/1953) and negative, hostile feelings or aggression, and thus may range from healthy self-assertion to self-abnegation (Green, 2002). From an object relations perspective, normal narcissism involves not just investment in the representation of the self but in a self that contains valued representations of others (referred to as *objects*). In psychodynamic thinking, the object refers to an internal mental representation that encompasses the actual other person but is also subject to modification by affect, impulse, wish, and fantasy. Normal or adaptive narcissism involves positive self-regard based on realistic self-appraisal. It involves pleasurable self-affirmation established and sustained through the individual's internalization of an accretion of positive, affirming experiences with others that promote stable and robust self-esteem regardless of the vicissitudes of life and relationships. With adaptive narcissism there is a sense of mastery and agency to realize the needs for self-realization and validation from others (Pincus & Roche, 2011; Kernberg, 2018; Ronningstam, 2016). The wish to shine, enhance the self through realistic goals and aspirations, be admired and respected by others, and live up to one's ideals and values are universally recognized as adaptive narcissistic strivings (Kohut, 1977; Kernberg, 1975), but from an object relations perspective, healthy adaptive narcissism has a specific meaning. Adaptive narcissism is a correlate of an integrated self-experience in which representations of self and other are clearly differentiated; positive and negative affects are well integrated and modulated; and the ideal self, which embodies the goals and aspirations one has, are commensurate with the individual's actual capacities and talents. Adaptive narcissism thus involves a sense of continuity and integration of myriad aspects of self-experience across time that sets the stage for a coherent and stable sense of identity that in turn allows for emotional engagement and investment in in-depth relationships with others.

From an object relations perspective, both an integrated self and the capacity for relatedness are built on a rich internal world of mental representations of gratifying relationships with others that shield one from the sense of emptiness, depletion, and futility, and/or the relentless striving for adulation often experienced by those with pathological narcissism. In sum, healthy narcissism is essential for adaptive self and interpersonal functioning. This is evident in the gratification and investment in realistic ambitions and achievements; in vital relationships that blend self-enhancement with love for others as unique and valued

individuals separate from the needs of the self; in an integrated system of ethical principles that encompasses both individual values and culturally sanctioned standards, while preserving a tension between the two that leaves room for independent thought and action separate from group norms; and in dedication to goals and ideals that guide work, creative, and/or intellectual pursuits. The concept of narcissism thus encompasses normative strivings for perfection, mastery, and wholeness, as well as pathological, defensive distortions of these strivings.

Pathological narcissism by contrast involves extreme, rigid needs for self enhancement and validation from others with fluctuations in self-esteem and emotional dysregulation in the form of angry outbursts, emotional withdrawal, or detachment from others when such needs are not met. Although most narcissistic individuals have tenuous self-esteem, due to a lack of integration of positive/idealized or negative/devalued aspects of experience, narcissistic pathology exists at different levels of severity. At the higher levels are individuals with non-specific self-centeredness on the cusp of neurosis who maintain a surface presentation of appropriate functioning in work and social life, and are able to sustain stable, but superficial, love relations. At the more severe levels are those who have pervasive defects in their capacity for work or profession and an inability to invest in love relations beyond transient sexual involvements. These individuals also demonstrate more aggressive reactivity to threats to their self-esteem. Whereas healthy narcissism is a component of an integrated self-experience and integrated concept of significant others, pathological narcissism involves investment in an internal world combining alternately highly idealized and devalued representations of self and others with the devalued aspects of self continually projected onto others. Consequently, others are not seen realistically as multifaceted and unique but in terms of the projected devalued or idealized aspects of self. Such a bifurcated experience of self and others creates fluctuations in self and affect regulation since the individual oscillates between a positive, exalted sense of self as superior and special, and a negative, devalued sense of self as inadequate and worthless. There are not integrated and differentiated mental representations to anchor the self in the face of the inevitable vicissitudes in life and relationships. These discontinuities in the experience of self and significant others lead to disruptions in the sense of identity and capacity to sustain relationships. Pathological narcissism thus evolves from a complex, dynamic spiral of self and relational processes—the precise strands of which may vary from individual to individual or within the individual over time. For example, many individuals with narcissistic pathology hold a view of the self as superior and others as devalued, although they may be quite charming and adept at eliciting the admiration and adulation they crave from others deemed inferior, or they may inordinately

idealize others and present the self as humble, self-effacing, insecure, shy, and subservient. But in either case, the complexity of positive and negative aspects of self and others is eliminated and the capacity for self-reflection or self-observation is limited.

Many individuals with narcissistic pathology have arranged their work and personal lives to garner the admiration and adulation they crave, but over time they have difficulty regulating their negative emotions when they are unable to obtain the veneration from others on which their psychic equilibrium depends. This may lead to increased antagonism toward others who then withdraw their positive regard thereby increasing the insularity and isolation of the narcissistic individual. Consequently, narcissistic grandiosity is inherently unstable, poised to shift into states of narcissistic vulnerability, which leaves the individual at risk for being overwhelmed by the negative affects of anger, envy, and fear. With more disturbed individuals, severe self-loathing and shame may ensue, leading to escalating and highly lethal destructive and self-destructive actions (Ansell et al., 2015; Blasco-Fontecilla et al., 2009). Indeed, for those with narcissistic pathology, the grandiosity and dismissing devaluation of others may mask a sense of "emptiness and futility," or at worst, "a hungry, enraged, empty self, full of impotent anger" (Kernberg, 1975, p. 633).

Individuals who suffer from pathological narcissism often present in contradictory ways, with their considerable strengths (verbal fluency, social competence, self-reliance) often obscuring their internal distress and suffering, which they have difficulty revealing or sometimes even experiencing consciously. Subjective feelings of distress may range from episodic feelings of worthlessness, emptiness, loneliness, and incompetence to devastating feelings of shame, isolation, crippling envy, and overwhelming self- or other-directed hostility—aspects of the vulnerable self-states to which these individuals are prone, especially in the face of threats to self-esteem, status, or control. At the more disturbed extreme, when the individual has antisocial or psychopathic features, patients with narcissistic pathology can also present with extreme levels of hostility and vengefulness, as is the case in those with the syndrome of malignant narcissism.

Thus, pathological narcissism may have varied presentations beyond the narrowly focused DSM-5 criteria, and may exist at different levels of severity depending on the underlying personality organization of the individual. At the least severe level, pathological narcissism may be evident in certain personality features, such as grandiosity, exaggerated self-importance, shame proneness, antagonism, entitlement, and/or exploitativeness (Miller, Lynam, & Campbell, 2016; Miller, Lynam, Hyatt, & Campbell, 2017). At this level, these features may be transient and catalyzed in certain situations, social contexts, or developmental

periods over the life cycle and do not necessarily involve the pathological self-structure characteristic of NPD. At the more severe end of the spectrum, pathological narcissism may manifest as an enduring personality disorder in which individuals are characterized by rigid, maladaptive, and problematic patterns of experiencing self and others that derive from a pathological grandiose self-structure. In sum, narcissistic pathology can manifest in multiple and often contradictory presentations and exist at different levels of severity, both within the individual at different points in time, and between individuals who have different levels of psychological organization. This complexity adds to the difficulty in diagnosing and treating narcissistic persons.

## An Object Relations Approach to Treatment of NPD

Our treatment model is transference-focused psychotherapy (TFP), a manualized evidence-based therapy for individuals with borderline personality disorders (BPDs), including many with NPD (Clarkin et al., 2007; Doering et al., 2010). The model has an integrated object relations theoretical framework developed by the members of the Personality Disorders Institute (PDI) at Weill Cornell Medical College from their experience in treating a range of patients with narcissistic pathology at different levels of personality organization, from high-functioning to more severely disturbed individuals. In developing our treatment approach to a spectrum of narcissistic patients, including those with NPD, we have been working on two fronts. First, through in-depth clinical discussion in a weekly supervision group conducted over the past 10 years we followed a number of cases of individuals with pathological narcissism being treated with TFP. We started the supervision because we found that patients with narcissistic pathology posed unique challenges including treatment stalemates and/or prolonged nonproductive treatments, or complex intense countertransference reactions including feelings of anger, hopelessness, or idealization on the part of even the most seasoned therapists. To find out more about these patients, we turned to data from our randomized clinical trials (RCTs), which allowed the opportunity to investigate the characteristics and course of treatment of patients with co-occurring narcissistic and borderline personality pathology. TFP was developed originally for patients with BPD—however, our experience conducting TFP with a range of patients with narcissistic pathology, including those with co-occurring narcissistic and borderline pathology (NPD/BPD) in our research studies, along with research findings described later in this book, all suggest that TFP with some refinements to the technique is useful for treating individuals with pathological narcissism including specific NPD.

NPD and pathological narcissism in the broader sense have been subject to a great deal of attention from clinicians and clinical researchers but, with few exceptions (Diamond et al., 2013; Diamond & Hersh, 2020; Gabbard & Crisp, 2018; Ronningstam, 2020; Kernberg, 1975, 1984, 2018; Kohut, 1971, 1977; Unruh & Drozek, 2020), the development of systematic treatment approaches for patients with pathological narcissism across the spectrum of levels of organization have not kept pace. Consequently, the working clinician may be confronted with an almost dizzying array of theories and research on all facets of narcissistic pathology—from neurobiology to etiology to personality traits—but may have little idea how these translate into actual clinical approaches or how such approaches may be tailored for the range of narcissistic spectrum symptomatology. Significantly, the first delineation of narcissistic pathology derived from clinicians' observations of the ways that pathological narcissism influenced aspects of the psychotherapy process and outcome. Their observations included narcissistic patients' difficulty in forming a working alliance or attachment to the therapist, or even in engaging in the treatment process at all; their allergic response to interpretation; and particular maladaptive transference–countertransference patterns that evolved in the course of treatment (Ellison, Levy, Cain, Ansell, & Pincus, 2013; Hilsenroth, Holdwick, Castlebury, & Blais, 1998; Stern, 1938; Kernberg, 1975, 1984; Kohut, 1971, 1977; Bach, 1985; Bromberg, 1996; Gabbard, 1989; Ronningstam, 2012, 2018). More recently there has been a groundswell of interest in the development of psychotherapies specifically targeted for pathological narcissism and NPD (Kealy & Ogrodniczuk, 2011, 2014; Ronningstam, 2016, 2018; Drozek & Unruh, 2020; Weinberg & Ronningstam, 2020) based on treatments for personality disorders with which NPD is highly comorbid, such as BPD, but few of these treatments are based in evidence (Paris, 2014) and/or described systematically in treatment manuals (Yeomans, Clarkin, & Kernberg, 2015). Although the research findings on the efficacy and effectiveness of TFP are for BPD only, it is a therapy developed for patients with personality disorders across the spectrum of severity and diagnoses, including those with narcissistic pathology, although they may present somewhat differently from patients with BPD.

People with NPD have been distinguished from those with other personality disorders by specific factors, such as arrogance or self-importance, grandiosity, envy, and excessive need for admiration (Sharp et al., 2015)—all of which are ways to cope in the face of threats to self-esteem. Individuals with narcissistic pathology may show more stability in their sense of self, which may allow for high levels of functioning in work or creativity, but this is often in glaring contradiction to the greater degree of disturbance in interpersonal and especially intimate

relationships. Like those with BPD, they may rely on splitting-based and dissociative defenses. However, this is less evident because of the tendency to rigidly and fixedly project negative aspects of their own experience onto others and immediately appropriate all that is good in others to the self (introjection) to bolster self-esteem and ward off challenge to narcissistic equilibrium. In addition, individuals with pathological narcissism tend to deny or discount aspects of reality that do not affirm their often inflated self-concept, leading more severely disturbed individuals to grossly deficient reality testing in which whole sectors of reality that do not conform to grandiose self-concept are discounted or even denied.

These characteristics may be more or less severe depending on the level of organization and the presence of other co-occurring characterological features or personality disorders. Perhaps most central to the object relations perspective on which TFP is based is the emphasis that individuals with pathological narcissism may span the spectrum of personality organization from higher functioning to low-level borderline. This understanding sees narcissistic pathology in dimensional terms. Having said that, our object relations model of pathological narcissism is based on a particular psychological structure—the pathological grandiose self—which introduces a categorical element to our thinking. Our conceptualization of this structure is a heuristic tool that helps define a particular manifestation of pathological narcissism and how to understand it and approach it therapeutically.



## Case Examples

The following case vignettes illustrate the range of individuals with narcissistic pathology across the spectrum of functioning encountered in clinical practice. All cases are composites to protect confidentiality.

### *Case Example: Mark—High-Functioning Narcissistic Disorder*

A renowned 40-year-old architectural engineer, Mark began therapy stating that he did not expect to learn anything about himself that he did not already know but just wanted someone to hold his hand while he dealt with a crisis in his relationship. Mark was torn between a young woman with whom he had become enamored in cyberspace and his long-term on-again, off-again girlfriend, who was threatening to end their relationship if he did not make a more enduring commitment and stop his Internet liaisons, of which she had recently become aware. In this dilemma, Mark became severely anxious and sought further treatment. He expressed feelings of futility about ever being able to sustain

sexual interest in a woman for the long term and seemed driven to seek out ideal fantasy figures that embodied a sense of perfection that he himself aspired to. Mark had been referred by his former CBT therapist, who felt that he needed more intensive therapy to work through his personality difficulties, including his lingering performance anxiety despite his success at work; his inability to commit to an enduring, intimate relationship; and his intermittent binge drinking. Although he reported transient infatuations with women he met socially or on the Internet, the attraction of these idealized fantasy figures withered when he met them in person and began to make demands on him for an ongoing mutual relationship.

When he began treatment, Mark was in the grip of a conflict between his current partner and a woman he had met on the Internet (whom he described as a paragon of perfection). He believed that being with such a woman would make him the target of envy, yet he feared that he would become disillusioned should he actually embark on a real relationship with her. Although he felt little sexual attraction to his current girlfriend, he could not imagine his life without her and the sense of comfort and security she provided. Yet he refused to commit to having children with her for fear it would curtail his career or close off other relational options. He chronically devalued her as unworthy, not accomplished, or not attractive enough, even though she was from an affluent socially prominent family that had elevated his own social status. Chronically dissatisfied, he could not bring himself to end the relationship, and felt baffled by his inability to do so. Mark was at the top of his profession and a partner in his firm, but he also presented with difficulties at work that stemmed from lingering debilitating performance anxiety and self-doubt about his creative abilities. He experienced periodic bouts of depression and anxiety when his designs, which were sometimes spectacular but impractical, were criticized by his coworkers or clients. He was riding on his past accomplishments and accolades but in fact had produced little new work for the past 3 years. As a result, his client base was dwindling, where before he had turned many away, and he was unwilling to search out new clients when the economic situation led to retrenchment in his company. Mark was a devoted mentor to the junior people in his firm but would withdraw support when they became successful in their own right. On the other hand, he was extremely generous to his few close friends, and had funded an engineering scholarship at his university designed for students in the Asian countries where he had worked.

Mark's father, a successful artist, was a "mythic figure" whom the patient felt he could never live up to and who demeaned architecture as a second-rate profession, while he publicly claimed credit for his son's

success at awards ceremonies. Mark described his mother, a successful art dealer, as a stunning narcissist who skimmed the surface of life and never went beyond that. He portrayed his parents' marriage as a perfect union, an ideal relationship that he could never attain. The parents had traveled a great deal during his childhood due to the father's involvement with lecturing and exhibition tours, and he was often left with a nanny or grandmother who lived with the family.

Indeed, Mark presented initially with features of a narcissistic personality organized at a higher level. His sense of exaggerated self-importance, need for admiration, and sense of entitlement were combined with a reasonably stable sense of identity that allowed for significant achievements in work and for long-term, albeit superficial and unsatisfying, relationships. His need to be special and always in the limelight at work left him vulnerable to self-criticism and to the criticism of others. His sense of self was buttressed by real talents and accomplishments, but he remained overly reliant on the valuation of others for self-definition and self-esteem regulation. His capacity for a deeper investment in an intimate relationship was limited since others were not seen realistically as autonomous beings separate from his narcissistic needs. Consequently, Mark was plagued by feelings of loneliness, futility, and loss of meaning in his life and work. His sense of ethical values was largely intact but somewhat inconsistent. On the one hand, he was altruistic and funded an art school in an Asian country he had worked in, but there were ethical lapses around split-off areas of functioning, such as using the office computer for Internet liaisons, which was against company policy. In short, he presented with many of the contradictions observed in those with pathological narcissism at a higher-functioning level: His veneer of social competence and ease vied with sudden withdrawal into states of painful and paralyzing self-doubt, or callous behavior toward others when he felt criticized and/or his expectations for admiration and approval were not met. He lacked empathy for and investment in those he was most intimate with, yet gratification in philanthropic activities made him feel influential and worthy. His façade of invincibility and social dominance combined with episodic plunges into states of worthlessness and self-loathing when his eminence or competence at work were challenged. And a sense of supremacy and self-sufficiency masked underlying insecurities about his capacity to love and be loved.



### *Case Example: Rebecca—Narcissistic Disorder Functioning at a Borderline Level*

Rebecca, a single Asian woman in her mid-20s, presented for therapy while in the midst of steady decline, brought on by what appeared to be

a major depressive episode. From a high-achieving family with a father who was a partner in a prestigious law firm, she had been designated as the perfect child who would fulfill the family legacy by studying law and entering the family firm. Her mother was depressed throughout Rebecca's childhood, sometimes unable to get out of bed to care for self and family. Although Rebecca had performed adequately at a prestigious college, she was in fact quite socially and sexually inhibited, at times feeling no man was good enough for her to commit to, and at other times, feeling hopelessly inadequate and unattractive. She described herself as "the pretty one" who was envied by her mother and sisters, even though she also expressed feelings of self-loathing. Her identity and sense of self were bound up with parental expectations. When Rebecca failed to achieve a score on the Law School Admission Test (LSAT) that would enable her to attend a top-tier law school, she got a job as a paralegal, but began to show symptoms of depression and anxiety, and performed poorly at work. When her best friend was admitted to law school, Rebecca cut off all contact with others, stopped going to work, and sequestered herself in her apartment, binge eating and rarely bathing. She refused to respond to phone calls, e-mails, or texts from her family, friends, and her psychiatrist. When her family became so concerned that they called 911 to check on her, she deemed this an intrusive overreaction. She had little regard for the impact of her withdrawal on her family. In the face of her decline in functioning, and her escalating suicidality, a psychiatrist whom she saw intermittently had prescribed a variety of pharmacotherapies, none of which had been particularly effective. By the time Rebecca was referred for TFP, she was on a complex cocktail of medications that made her feel "like a zombie" and was isolated in her apartment. She spent her days watching reruns of legal shows and fantasizing about being an accomplished lawyer, sporadically attempting to study for the LSAT to improve her scores, yet accomplishing very little. Although she felt controlled by the demands for contact by the significant figures in her life, she expected both parents and her boyfriend to be immediately available when she felt like contacting them, yet kept them at bay for long periods.



Rebecca epitomizes an individual with pathological narcissism in the context of *borderline personality organization* (BPO). BPO is a concept derived from the "structural" system of classification of personality disorders proposed by Kernberg (1984). This diagnostic system emphasizes dimensions (e.g., identity, defenses, ethical functioning, reality testing, object relations) in contrast to the more categorical DSM system (DSM-5; American Psychiatric Association, 2013), with a focus on both the underlying psychological structural components of personality disorders and also the levels of severity of these disorders (Caligor, Kernberg, Clarkin, & Yeomans, 2018). While these patients may or may not have the signs and symptoms of comorbid BPD, including self-destructive

behaviors, overt chronic fears of abandonment, extreme affective instability, behavioral impulsivity, and chaotic interpersonal relationships, they are organized at a broader borderline level in terms of underlying psychological structure, which is further described in Chapter 2.

### *Case Example: Michael—Malignant Narcissism with Borderline Personality Organization*

Michael, an aspiring White male artist in his mid 20's, had a long history of self-injurious behaviors and multiple relationships based on exploitation and substance abuse, as well as bouts of depression and anxiety. He had several hospitalizations for suicidality and a number of outpatient treatments that failed to stabilize his symptoms before he was referred for TFP. During his treatment, he told his therapist, "I've been on the Internet and I don't think you talk enough about my narcissism. . . . I also found out where you live and I just might show up there." When Michael was 5 years old, his mother became disabled in a car accident that had also killed his younger brother. His mother developed a major depression and was unable to care for Michael, instead turning to him for emotional support and caregiving. His mother was also inappropriately seductive, at times exposing herself to Michael and demanding that he put her to bed. Michael's father, who was a successful executive in the entertainment business, traveled often for work, leaving Michael at home to care for his mother. His father encouraged Michael's considerable talents as an artist, performer, and athlete, and instilled in him the sense that he was unusually good-looking, gifted, and destined for unique success. However, his father drank heavily and had rage attacks, during which he sometimes was physically abusive to Michael.

Michael attended a competitive high school for gifted students and had exhibited his paintings in several galleries in shows for student work, but his intermittent self-destructiveness, affective instability, and antisocial behaviors (including missing classes, feigning illness, and lying to his mentors) made it difficult for him to develop his talents in any sustained way. He attended a prominent art and design college, but ultimately dropped out, and was hospitalized for self-injury (lacerating his arms and legs) and substance abuse, after which he took art classes without progressing toward a degree. At 23 he fell in love and married a woman from a socially prominent, wealthy family, who was captivated by his charm, while supporting him financially and excusing his erratic behaviors as the result of an "artistic temperament." Michael was chronically unfaithful to his wife, and denied her wish to start a family because he believed he was "too sick" to become a father.

In the first month of treatment, Michael began an affair with a woman he met in Alcoholics Anonymous (AA). The two developed a

murder–suicide pact to be carried out in the therapist's office, with a plan that would potentially endanger the therapist as well. Michael talked about this plan during a session with his therapist with an excitement that bordered on glee, especially about his imagined ability to trick the therapist and "pull it off," if he wished, even after having described the plan to his therapist. He imagined leaving her hurt, bewildered, and defeated. The therapist pointed out that he seemed to enjoy the idea that his talk of the plan was designed to make the therapist feel fearful and humiliated. For Michael, then, the sense of grandiosity was infused with ego-syntonic aggression fueled by paranoid feelings that the therapist might harm or injure him—beliefs that he used to justify his callous manipulation of the therapist and others, and his potentially harmful actions—all of which characterize the syndrome of malignant narcissism.

In later chapters, we return to these and other cases of individuals treated productively in TFP. We offer them here to highlight the complexities of diagnosing and treating individuals with pathological narcissism, and the myriad forms that pathological narcissism can take, as well as the range of levels of impairment that it may involve. Some of the difficulties in diagnosing and treating individuals with pathological narcissism thus stem from the fact that it can manifest itself in opposing ways (e.g., grandiose or vulnerable) that may be expressed either overtly in behavior and attitudes, or covertly in feelings, beliefs, cognitions, and fantasies (Pincus & Lukowitsky, 2010), within the same individual over time. Furthermore, the dual faces of grandiosity and vulnerability may be expressed in different admixtures for individuals at different levels of severity, as the case examples indicate. Although either grandiose or vulnerable features may dominate the initial presentation, in those with narcissistic pathology, *grandiosity and vulnerability almost always coexist in dynamic relationship to each other.* In those with a grandiose presentation, attitudes of superiority and seeming invincibility defend against inner, subjective states of vulnerability, shame, self-doubt, distress, and neediness. By contrast, a vulnerable presentation of humility, self-doubt, shame proneness, and inferiority may camouflage covert grandiose beliefs about the self as superior and special, either destined for unique greatness, or distinguished by unique suffering.



## NPD and Personality Organization

Contemporary object relations theorists (Kernberg, 1984, 2007) have long stipulated that personality disorders are associated with fundamental disturbances in self and interpersonal functioning that vary in

severity within and across disorders. In this regard, the object relations approach that informs our theory and treatment of pathological narcissism and NPD is consistent with the hybrid dimensional/categorical view of personality disorders delineated in the "Alternative Model for Personality Disorders" (AMPD) Section III of DSM-5 (American Psychiatric Association, 2013). The AMPD stipulates that personality disorders, including NPD, are characterized by impairments from mild to moderate severity in the dimensions of self (self-identity, self-direction) and interpersonal functioning (intimacy and empathy), referred to as Criterion A. For those with NPD, disturbances in the sense of identity involve an overreliance on the opinions of others for self-definition and fluctuations in self-esteem regulation, which may inflate or deflate depending on the valuations of others. Difficulties in self-direction as a result or inordinate reliance on gaining approval of others, with standards either too high because of an unrealistic view of self as exceptional, or too low based on entitled expectations, can also disturb a sense of identity. Impairments in interpersonal functioning are characterized by deficits in intimacy evident in the tendency to form shallow, superficial relationships with others and/or a disinterest in those who do not provide admiration. Also evident is an impaired capacity for empathy or the ability to experience and identify with the feelings of others, although there may be a heightened intellectual understanding of the feelings of others sometimes used to advance their own interests (American Psychiatric Association, 2013). In addition, the characteristics of grandiosity, or the feelings of superiority, entitlement, and self-centeredness, and attention seeking, or the attempts to garner admiration, are required for an NPD diagnosis. Other traits, such as antagonism and negative affectivity (depression, anxiety), may also be added on as specifiers to capture vulnerable presentations of pathological narcissism.

The object relations model that informs TFP also conceptualizes the impairments of self and interpersonal functioning as core dimensions of pathological narcissism NPD that vary in severity depending on the individual's level of personality organization. But it goes beyond the AMPD model to include dynamic features, such as defensive functioning and ethical values (Clarkin, Caligor, & Sowislow, 2019). Most important is the level of integration and developmental quality of the individual's mental representations of self and significant others as crucial dimensions in understanding the intrapsychic structural features of those with pathological narcissism and NPD. In the object relations perspective, impairments in all of these dimensions are linked to a particular underlying structural constellation of ideal and devalued mental representations of self and other that characterizes the grandiose self. The descriptive criteria found in the DSM-5 NPD category, the contradictory characteristics of grandiosity or vulnerability highlighted in

the diagnostic system of the second edition of *Psychodynamic Diagnostic Manual* (PDM-2; Lingiardi & McWilliams, 2015) and the hybrid dimensional/categorical AMPD, which emphasizes impairments in self and interpersonal functioning—all may be seen as expressions of investment in different facets of the underlying grandiose self-structure that is paradigmatic of pathological narcissism. Accordingly, when we use the terms *pathological narcissism*, *narcissistic pathology*, or *narcissistic personality disorder* in this book, we are referring to a structural conception of the disorder that combines both categorical and dimensional features. We discuss these issues in more detail in later chapters.

## Levels of Personality Organization

From an object relations perspective, the level of personality organization (i.e., high functioning [neurotic], borderline, or psychotic) is determined not only by the level of functioning across the dimensions of self and interpersonal domains but also the extent to which mental representations of self and other are integrated (e.g., how well positive and negative aspects are balanced and modulated) and differentiated (e.g., the extent to which concepts of self and other are separate and distinct). At the highest level, there are individuals with conflicts around narcissism. But in the context of a reasonably consolidated identity based on realistic, integrated, and differentiated mental representations that allow for the capacity to invest and take pleasure in enduring relationships to adhere to a solid system of ethical values and to maintain intact and stable reality testing—these are all characteristics of those in the normal or neurotic realm. In these individuals, we do not see the impoverishment of object relations characteristics of those with more severe narcissistic pathology—rather, there is a level of mutuality, warmth, flexibility, consistency, and complexity to the inner object world. Instead, we see transient exaggerations of the normative narcissistic strivings to receive recognition, respect, and appreciation for one's accomplishments and characteristics.

For example, a high-functioning professional woman, a partner in a major law firm with a successful career and deep, enduring friendships, occasionally regresses to childish demanding behavior when she feels not respected or attended to by her partner with whom she shares a gratifying emotional and sexual relationship. But this represents not so much distorted, polarized representations of others or an exaggerated, inflated sense of self but unresolved conflicts around an identification with an inconsistently available, but loving maternal figure that could be confronted and worked through in treatment. Similarly, a male patient, a writer who had struggled for a decade to write a definitive biography,

was supported by a wife whom he loved deeply and with whom he shared many intellectual interests. When his book soared to the top of the best-seller list, he became self-preoccupied and self-important, basking in the respect and adulation he received on book tours, neglecting the emotional needs of his wife and close friends with whom he had been previously attuned and responsive. When his wife expressed her unhappiness and dissatisfaction and requested couple therapy, he was able to acknowledge that his newfound celebrity had eclipsed other aspects of his life and was able to use the therapy productively to work on reestablishing their intimacy. The couple therapy led to the exploration of some unresolved issues about the ways his neglect of his family stemmed from an unconscious identification with his father, a talented but frustrated writer whose own career had been stalled when he took a job as an executive in publishing to support the family, thereafter projecting his aspirations onto his son while devaluing his failing marriage. In sum, individuals at a higher level of organization in some situations (escalation of prominence, wealth, etc.) may show narcissistic features, such as exaggerated self-importance, entitled expectations, desire for admiration, or antagonism. However, these are often transient and occur in the context of a relatively good overall adaptation and a reasonably stable, complex, and multifaceted sense of identity that is not distorted by an illusory rigid grandiose self, and allows for enduring—even if sometimes conflicted—relationships in depth.

Higher-functioning individuals with pathological narcissism and NPD, in contrast to those with narcissistic traits, may present similarly to those described above. They are often quite charming, accomplished, socially adept, and successful at garnering the approval, admiration, and veneration of others. But they respond to criticism or threats to self-esteem not with reflection and dialogue but with hostility, withdrawal, and/or rejection of others who challenge them, and further in the face of more serious challenges (e.g., loss of a job or relationship, or financial reversals), aspects of reality that fail to confirm their illusions about the self may be denied or rejected. In addition, higher-functioning narcissistic personalities often have seemingly gratifying relationships, but these are often superficial and lacking in mutuality and depth, and/or are organized to meet inordinate needs for admiration. They experience disturbances in the sense of self from vague feelings of futility and emptiness to more profound states of despair, and thus do not have the cohesive, integrated identity characteristic of those with higher-level organization, although they may sometimes present as such, and hence, may be seen as on the cusp of neurotic organization. However, in the face of challenges to the narcissistic equilibrium, such as the inevitable losses, developmental transitions, and/or disappointments of life, such individuals

may become quite symptomatic, experiencing anxiety, depression, or somatic symptoms that fail to abate with focal short-term treatments. In such situations, the excessive reliance on the admiration of others to regulate self-esteem, the fluctuations in self-esteem and affective instability, the compromised capacity to recognize or share their own internal distress, the lack of recognition or empathy for the distress they cause in others, the need to see the self as exceptional regardless of the views of others—all evidence of underlying narcissistic structure—emerge. So, the potential for developing narcissistic pathology may not emerge fully in such high-functioning individuals until there is a life crisis that precipitates the acute onset of more severe symptomatology and personality pathology (Ronningstam, 2011; Ronningstam, Gunderson, & Lyons, 1995; Simon, 2002). At that point, higher-functioning individuals may present with characteristics of borderline organization (e.g., identity disturbances, affective instability, impulsivity).

Clinical investigation has identified midlife as a critical period for the development of narcissistic personality pathology for individuals who function at a higher level (Kernberg, 2007; Ronningstam, 2010). Such individuals may remain asymptomatic in the early part of the life cycle (young adulthood) when their narcissism is well regulated by the admiration that their considerable talents and accomplishments evoke, but narcissistic pathology may develop or worsen in midlife, which inevitably brings confrontation with limitations, losses, and mortality. It is in midlife that characteristic attitudes of exploitativeness, entitlement, lack of empathy, and relentless use of others to regulate narcissistic needs for self-enhancement lead to erosion of love relationships, and/or disillusionment or conflicts around work (Ronningstam & Maltsberger, 1998; Kernberg, 1975, 2007, 2018). In such situations, the inability to access a rich and sustaining internal world of mental representations leave these individuals feeling a sense of emptiness or futility as they confront the gap between their external success and the impoverishment of their relational lives, even when there is not a major discrepancy between ambitions and accomplishments. Such was the case with Mark described earlier, who presented for treatment at age 40 in the midst of a crisis brought on by his conflict between a fantasy-fueled Internet relationship with an idealized unattainable woman and a long-term, devoted but devalued partner. It is noteworthy that in high-functioning individuals like Mark, grandiosity, which is likely to be more dominant earlier in the life cycle, may be relatively adaptive in that it propels the individual toward realizing his or her goals and aspirations and gives the individual the confidence to do so.

In individuals with narcissistic disorder with lower-level borderline organization, there are the core narcissistic features of grandiosity,

entitlement rage, and exploitativeness, but in addition, there is more extreme vulnerability typical of nonspecific personality pathology (Wright & Edershile, 2018). There are more extreme fluctuations between grandiose and vulnerable self-states, leading to a more fragmented sense of identity (Di Pierro, Di Sarno, Preti, Di Mattei, & Madeddu, 2017), with less integration between aspects of self that are aspired to and those that are disowned or denied. This makes it difficult to develop consistent goals and limits the capacity to invest in or sustain intimate relationships with others. These impairments in interpersonal functioning may be the outward manifestations of a deterioration or distortion in the internal world of object relations, leading to a chronic sense of emptiness and boredom that can be overcome only by the continual seeking of external excitement with an ever-changing array of people and experiences. Negative feelings, such as envy, fear, and anger, are not well integrated or tolerated, but dealt with through the systematic devaluation of others, particularly if the others have capacities or accomplishments the individual desires for his or her own. In addition, those with narcissistic pathology with BPO present with a grandiose sense of self that is grossly discrepant with their real attributes and accomplishments, along with impulsivity, poor anxiety tolerance, and split, polarized object relations. This leads to chronic, rather than episodic, failures in work and intimate relationships. Individuals are likely to react with rage, extreme withdrawal, or emotional collapse when threatened, despite some defensive functions provided by the pathological grandiose self (Kernberg, 2007). Rebecca, who collapsed when she failed to live up to her unrealistic expectations of herself, epitomizes the vulnerable narcissistic individual with a low borderline organization. Symptomatic stress may be seen in late adolescence and young adulthood with its testing of the self beyond school and family. It is often evident in the syndrome of failure to launch.

At the more disturbed end of the spectrum of pathological narcissism (lower level of borderline organization) is the inability to tolerate or manage aggressive and negative affects, such as anger or envy that may lead to the wish not only to devalue others but to destroy the good things they possess, often leading to the deterioration of relationships, both internal and external, with significant others. In addition, in individuals with more severe narcissistic pathology, there is greater deterioration of object relations and superego functioning evident in the lack of a coherent system of ethical values, with adherence to rules and standards mostly out of fear of being caught or exposed, marked antisocial features, paranoia, and ego-syntonic aggression characteristic of malignant narcissism. Michael, the third case presented earlier, had a history of psychopathic attitudes and behaviors (chronic lying), self- and other-directed destructiveness that stemmed from identification with a

corrupt parental figure who was abusive but also treated him as special. Michael showed many aspects of malignant narcissism, including vengeful destructiveness toward others evident in the murder–suicide pact he formed with another patient.

In sum, an object relations perspective proposes specific distortions in the dimensions of identity, defenses, reality testing, superego functioning (ethical values), and object relations, or the level of integration and developmental quality of mental representations of self and significant others that exist at different levels of severity. However, in our view, what distinguishes individuals with pathological narcissism across all levels of functioning from those with personality disorders in general is the specific constellation of ideal self and object representations: the pathological grandiose self.

## The Pathological Grandiose Self

The pathological grandiose self is a compensatory structure in which ideal representations of self and others (i.e., what one aspires to be through identification with admired others) overshadow the real self (i.e., a realistic sense of actual abilities and potential). Typical for the entire spectrum of narcissist pathology is the absence of a stable availability of a loving parental figure that provided a significant period of safe dependency, and fostered the elaboration, differentiation, and maturation of the child's real capacities and characteristics. Also, typical across the spectrum is some source of admiration that the patient obtained from significant others, whether for physical appearance, talents, or role in the family that served as a compensating experience by which the security derived from being admired would replace the security from being loved. These developments constitute the nucleus of what crystallizes as the pathological grandiose self.

In such circumstances, a positive inward sense of an authentic and vital self, separate from idealized images of self based on the approval of others, fails to develop. In contrast to those with BPD where the split between an idealized and devalued concept of self and others leads to a lack of integration in the self, the grandiose self of those with narcissistic disorder provides a semblance of integration. In the pathological grandiose self there is a condensation of real and ideal aspects of the self with the systematic projection of the negative aspects of the self onto others. Often some special aspect of the self that makes the individual admirable as an object for the parents or others forms the basis for an idealized sense of self that merges with ideal images of others, overshadowing the realistic images of the self and others. Since the ideal self, ideal

other, and real self are one, the individual does not feel the need to live up to moral values or standards of ideal others. Also, negative or devalued aspects of the self are condensed with those of others and systematically projected onto them in order to preserve the sense of specialness, uniqueness, supremacy, and infallibility that characterizes the grandiose self (Kernberg, 1975, 2007, 2018). But systematic devaluation of others truncates the process of further internalization of others because of their devalued status. Consequently, the individual cannot receive and value nurturance from devalued others. Such a grandiose self-structure leads to difficulties with (1) identity, in that the individual believes that he or she encapsulates all that is desirable and retreats to an illusory world to preserve such an inflated view of self; (2) self-direction, in that the individual relies on the admiration and adulation of others to shape aspirations and sustain goals; (3) interpersonal functioning, in that others serve self-regulatory purposes and are seen as extensions of the individual's own needs rather than valued as separate and unique others in their own right (Kernberg, 1975, 1984, 2007, 2015; Morf & Rhodewalt, 2001; Morf, Torchetti, & Schürch, 2011); and (4) distortions in ethical values and reality testing, in that aspects of reality that do not conform to the illusions of the grandiose self are distorted or rejected, leading at times to the disregarding of rules, social norms, and the consequences of such.

In higher-functioning narcissistic persons, the ideal aspects of the grandiose self are not so extreme as to eclipse the real aspects of self, allowing for some adequate adjustment, stable if shallow relationships, and reality orientation. In high-functioning individuals, the prevalence of positive libidinal aspects over aggressive aspects in the self makes them more accessible for relationships and for therapy. Such was the case with Mark, who was highly accomplished and successful at work but was deeply conflicted between idealized fantasy-laden relationships and his unsatisfying partnership with a woman whom he systematically devalued but could not leave. By contrast, in narcissistic persons functioning on an overt borderline level and/or those with malignant narcissism, aggression-laden, highly unrealistic ideal representations of self and others fuel the need to dominate and control others, severely limiting the capacity to work or to love and leading to more severe impairments in reality orientation. Such was the case with Michael, who enacted an unconscious identification with a highly idealized destructive paternal figure in his chaotic, exploitative relationships and fantasied vengeful behavior toward the therapist.

From an object relations perspective, the pathological grandiose self is a core structural feature of those with pathological narcissism, but the core dysfunction of pathological narcissism is not necessarily grandiosity

per se. Rather, in those with pathological narcissism or NPD, states of grandiosity coexist with feelings of inferiority and fears of loss of status and control—aspects of the vulnerable self-states to which these individuals are prone when the defensive functions of the pathological grandiose self falter, or when their excessive needs for admiration and validation are unmet (Kernberg, 1975; Levy, Beeney, & Temes, 2011; Roche, Pincus, Conroy, Hyde, & Ram, 2013). When these needs are in line with the individual's actual talents and capacities, they fuel the quest for experiences that enhance the self-aspects of normal or adaptive narcissistic strivings. Pathological narcissism is born of the extreme, exaggerated nature of such needs, and the inability to translate them into mature, realistic ambitions and strivings.

While we posit such a structural underpinning to narcissistic pathology, we are aware that each individual's structure may fluctuate according to internal and external stressors. We are also aware that clinicians may find in their practice individuals who may have characteristics of narcissism but may not have a pathological grandiose self as firmly fixed in place as do others with full NPD. In such cases, one may encounter patients with narcissistic features or traits without a pathological grandiose self-organization per se. In any case, it should be noted that structures including the pathological grandiose self are enduring and stable patterns of mental functions that organize the individual's behavior, perceptions, and subjective experience (Yeomans et al., 2015).



## Grandiose (Thick-Skinned) and Vulnerable (Thin-Skinned) Presentations of NPD

Orthogonal to the view of NPD as a dimensional disorder that exists along a spectrum of pathology, is thus the distinction between the two different presentations of narcissistic pathology. A grandiose or thick-skinned presentation involves an exaggerated sense of self-importance, strivings for social dominance and exploitation of others to attain it, and a sense of entitlement rage when it is threatened or challenged. These are all the overt manifestations of more covert cognitions, such as fantasies of unlimited success. A vulnerable or thin-skinned presentation is characterized by hypersensitivity to rejection, a sense of unworthiness, and feelings of inadequacy in the context of covert grandiose features evident primarily in fantasies, beliefs, and entitled expectations, the behavioral expression of which is curtailed by inhibition, self-effacement, and shame proneness (Kernberg, 1984; Cain, Pincus, & Ansell, 2008). While there is some evidence that the pathological grandiose self figures in both types of presentations, it may take somewhat different configurations.

The grandiose or thick-skinned narcissistic person may be characterized by a robust grandiose self-representation in which a thick defensive barrier keeps devalued aspects of the self more securely at bay. This was the case with Mark, described earlier, whose idealized Internet figure represented, in part, a projection of his own superiority, while his partner represented the devalued, dependent, disavowed aspects of self. By contrast, in the thin-skinned vulnerable individual, prone to states of extreme vulnerability, hypersensitivity, self-doubt, and even paranoia, the defensive barrier between idealized and devalued aspects of the self is thinner and more permeable. This was the case with Rebecca, whose preoccupation with grandiose fantasies of having a successful legal career was the primary driving force behind her retreat into a world of autistic fantasy when her unrealistic ambitions could not be realized. The vulnerable narcissistic organization was masked by her depressive symptomatology and collapse.

In sum, grandiosity and vulnerability may coexist, oscillate, or defend against one another in different ways in individuals with different levels of personality organization, and different characterological features. That pathological narcissism always coexists with impaired regulatory capacities that can lead to vulnerable states of helplessness, shame, fear, and social withdrawal is now backed up by clinical research on ecological momentary shifts in self-states on a daily or even hourly basis in those with narcissistic pathology. Several studies have shown mental state fluctuations from grandiosity to vulnerability in those with pathological narcissism and NPD in response to interpersonal interactions on a daily basis (Giacomin & Jordan, 2016; Roche et al., 2013). However, at least one study shows that the extent to which the individual is dispositionally vulnerable or grandiose affects the extent to which there were momentary fluctuations between the two states, with those who were rated higher on vulnerability showing the most variability between grandiosity and vulnerability (Edershile & Wright, 2019). Thus, further clinical and empirical research is necessary to understand whether these two presentations represent distinct categorical phenotypes or subtypes of the disorder, or fluctuating intra-individual mental states that oscillate over time in response to different conditions and life circumstances. As clinicians we do not observe a simple dichotomy between grandiosity or vulnerability. Rather, these dimensions, although fundamental to narcissistic pathology, may take on different configurations in individuals dependent on level of organization and characterological features. Those high in vulnerable narcissism have been found to suffer from more identity diffusion and may be more likely to be in the borderline realm in several studies (Di Pierro, Costantini, Benzi, Madeddu, & Preti, 2019).

## The Prevalence of NPD and Its Relationship with Other Disorders

Recent studies have shown rising rates of pathological narcissism and NPD both in the nonclinical and clinical groups. In a recent community study, the Wave 2 National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a representative sample of 35,000 Americans were asked in face-to-face interviews whether they had experienced symptoms of NPD over the course of their lifetime. Individuals had to endorse the requisite number of DSM-IV criteria for NPD, including at least one that caused significant social or occupational impairment or distress (Stinson et al., 2008). In the total sample, the prevalence of NPD was 6.2%. Interestingly, men were found to have higher rates of NPD than women (7.7% in contrast to 4.8%), and rates of NPD were particularly high among young adults between the ages of 20 and 29 (9.4%). They were also higher among those who were separated, widowed, divorced, or never married, perhaps indicating the difficulty the latter group of individuals have in forming and sustaining relationships. Also, higher rates were seen among Black males and Hispanic females, indicating perhaps the defensive function of NPD to deal with the injuries of minority status, a finding that necessitates further investigation. The overall prevalence rate of 6.2% in this study is markedly greater than that noted in the only other comparable study previously conducted in Oslo, Norway, which yielded an NPD rate of 0.8% (Torgersen, Kringlen, & Cramer, 2001), indicating perhaps that narcissistic pathology may be more prevalent in North American culture. However, a reanalysis of the data conducted by trained clinical researchers rather than research assistants who conducted the first study, and with more rigorous cutoff criteria that included the level of subjective distress and functional impairment, as well as DSM-IV diagnostic criteria, yielded lower prevalence rates of 1.0% (Trull, Jahng, Tomko, Wood, & Sher, 2010). A comparable prevalence rate of 1.0% was reported in a systematic review of several other community studies of NPD (Dhawan, Kunik, Oldham, & Coverdale, 2010). Even at these lower rates, as Paris (2014) points out, NPD is a highly prevalent disorder. Furthermore, it is likely that these prevalence rates are underestimated—first, because they are largely based on self-reports and persons with pathological narcissism have been found to be unreliable in their self-assessments. In fact, informants (peers or family) are over twice as likely to identify narcissistic pathology in individuals as are the individuals themselves on self-reports (Cooper, Balsis, & Oltmanns, 2012; Klonsky & Oltmanns, 2002). Second, this focus on the grandiose features of NPD may also account for the discrepancy in the rates of NPD in men and women, since self-report

assessments privilege the overt grandiose features of NPD, and women may be more prone to be characterized by the more covert, vulnerable features of the disorder (e.g., self-defeating attitudes and behavior, shame proneness, preoccupation with grandiose fantasy). A recent meta-analysis affirms that men tend to be more narcissistic than women across different cohorts and age groups and are more likely to be diagnosed with NPD, with measures of grandiose narcissism showing more prominent gender differences then do measures of vulnerable narcissism (Grijalva et al., 2015). Thus, the rates of NPD in both clinical and community groups may be increasing along with the rise in narcissistic traits in the general population, although the impact of gender, age, and cohort necessitates further investigation.[1] In clinical groups, the prevalence of NPD has been found to range from 2% (Zimmerman et al., 2005) to 6% (Grilo, McGlashan, & Quinlan, 1998) to 17% (Clarkin et al., 2007; Ronningstam, 2011), with greater levels of narcissistic pathology reported by psychoanalytic clinicians who tend to see patients for lengthier and in-depth treatments (Gabbard, 1997). These higher prevalence rates in clinical samples indicate that those with NPD experience enough distress to seek treatment, although the narcissistic pathology initially may be masked by other co-occurring disorders.



## Comorbidity and NPD

Many individuals with pathological narcissism and NPD often present with other co-occurring disorders, particularly unipolar and bipolar depression and anxiety disorders, although substance abuse, posttraumatic stress disorder, and eating disorders are also prevalent (Fossati et al., 2000; Simonsen & Simonsen, 2012; Zimmerman et al., 2005; Stinson et al., 2008). Depression in individuals with pathological narcissism often has distinct characteristics in that it is characterized by emptiness, nihilism, anhedonia, and a sense of futility and meaninglessness rather than by pervasive sadness, guilt, or preoccupation with a sense of unworthiness or loss. Our clinical observation is that depressive symptoms in patients with pathological narcissism tend to be precipitated by the collapse of entitled expectations and by recognition of the gap between the ideal and real self. Furthermore, mood and anxiety symptoms are often infused with anger, shame, and envy stemming from

[1]In a recent meta-analysis of gender differences in narcissism, men were more likely to be diagnosed with NPD, and scored higher on exploitativeness/entitlement (the most socially problematic aspect of narcissism; Ackerman, Hands, Donnellan, Hopwood, & Witt, 2017) and leadership/authority facets (Grijalva et al., 2015), than did women.

failure to meet perfectionistic standards. In sum, co-occurring mood disorders in the context of pathological narcissism may involve a particular configuration of external symptoms and internal experience of self and others.

In addition, there is a high degree of co-occurrence of NPD with other personality disorders, including histrionic, antisocial, borderline, schizotypal, and paranoid, in both community samples (i.e., 62.9% rate of comorbidity of NPD with other disorders; Stinson et al., 2008) and clinical samples (i.e., >50.0% rate of comorbidity; Clarkin et al., 2007; Gunderson, Ronningstam, & Smith, 1996; Pfohl, Coryell, Zimmerman, & Stangl, 1986; Zimmerman et al., 2005). The high rates of comorbidity between NPD and other personality disorders have led to debates about whether NPD is a distinct personality disorder or whether narcissistic pathology is a dimension that may characterize several other disorders. Interestingly, in a recent study, Sharp and colleagues (2015) evaluated the general (g) factors that might account for both common (underlying) variables or factors shared across DSM-5 personality disorders (e.g., identity, impulsivity), as well as specific, unique factors that may represent more specific forms of personality disorder pathology. Clear specific factors with strong average loadings emerged for only three personality disorders: narcissistic, antisocial, and schizotypal. Interestingly, the borderline disorder items loaded most strongly on the so-called general (g) factor of personality pathology (e.g., identity disturbance, affective instability, emptiness, self-harming impulsivity, interpersonal instability, intense anger, frantic efforts to avoid abandonment, and suicidality). Those with NPD were relatively weak on this g factor, but quite strong on the factors specific to NPD, such as grandiosity, envy, and arrogance. These findings suggest that while there is an overlap between NPD and other personality disorders reflected in the high rates of comorbidity, there are also specific characteristics of the disorder that set it apart as unique and distinct. This study supports the conceptualization of personality disorders both as distinct categories and as having varying dimensions and levels of personality pathology that are consistent with our object relations model.

In addition, the high rates of comorbidity make it likely that patients with other disorders will have significant narcissistic pathology that may affect their presentation and that will complicate the treatment process and outcome (Kernberg, 1984; Diamond & Yeomans, 2008). Interestingly, although assessing narcissistic pathology is complicated by the high rates of comorbidity, Gabbard (1997) has proposed that in more in-depth, intensive psychodynamic treatments, NPD may emerge as a primary diagnosis.

## NPD More Prevalent When Diagnosed by Clinicians

Interestingly, clinicians in outpatient private practice report higher rates of narcissistic pathology and NPD than do those in outpatient hospital-based clinics or community samples. For example, in one study, 510 psychoanalysts across three countries reported that 20.0% of their patients suffered from NPD as assessed by DSM-III-R criteria (Doidge et al., 2002), making it one of the most prevalent disorders in the United States and Ontario, Canada, and the second-ranked disorder in Australia. Regarding the difficulty in treating NPD patients, Doidge and colleagues also found that the majority of these patients had sought previous short-term treatments, which were unsuccessful. In another study in which NPD was assessed through interviews with patients that focused on their interpersonal functioning, as well as observations of their behavior with the interviewer, 76.0% of expert clinicians reported treating patients who met criteria for NPD (Westen, 1997). In an attempt to extend these findings and show that DSM NPD criteria do not capture the range of patients with nacissistic personality pathology seen by clinicians in practice, Westen and Arkowitz-Westen (1998) asked a sample of randomly selected experienced clinicians (psychiatrists and psychologists) with a range of theoretical orientations (44.8% psychodynamic, 16.1% cognitive behavioral, 34.3% eclectic; 36.4% psychiatrists, 63.6% psychologists) to report on the percentage of their patients who were diagnosable with DSM-IV NPD. They found that overall 8.5% of the 714 patients involved were reported to have a diagnosis of NPD. It is noteworthy that the psychodynamic clinicians reported the highest number of NPD patients (11.2%), followed by eclectic (5.7%), and then cognitive-behavioral clinicians (3.9%). The authors concluded that DSM-IV criteria are inadequate to assess the range of personality problems of those with personality disorders, including NPD. For example, a random sample of clinicians (psychologists and psychiatrists) defined pathological narcissism as a complex multifaceted construct that exists on a continuum of severity with core features of interpersonal vulnerability, inner distress, competitiveness, and difficulty regulating affect, particularly anger, not represented in the DSM (Russ, Shedler, Bradley, & Westen, 2008).

It is likely that psychodynamic clinicians tend to report somewhat higher levels of patients with pathological narcissism and NPD in their practices because they have a greater capacity to recognize the underlying personality dynamics, the impairments in self and interpersonal functioning, and the vulnerability to states of shame and self-loathing that may be obscured by the grandiose self-presentation of those with NPD. They also have more extensive training in theories of narcissism,

both normal and pathological, and hence, a greater capacity to recognize pathological narcissism and NPD, which may be masked by syptoms of depression, anxiety, and/or substance abuse and thus escape detection by colleagues without psychodynamic training who often refer patients for more intensive psychodynamic therapy after numerous short-term treatments have failed to alleviate their distress and/or behavioral problems. Indeed, a study conducted among CBT therapists found 14.0% of 742 patients were diagnosed with NPD, a figure that approaches the number diagnosed by the psychodynamic clinicians in the previous study (Westen & Arkowitz-Westen, 1998), indicating that in this study, there was a more rigorous assessment of the patients and/or that the CBT therapists making their own diagnosis in the Westen and Arkowitz-Westen study may have been underreporting.

In sum, recent studies have indicated that those with NPD now comprise 1.0–6.2% of those in community samples (Stinson et al., 2008; Trull et al., 2010), with higher rates (from 2.0 to 17.0%) in clinical samples (Westen & Shedler, 1999; Grilo et al., 1998; Clarkin et al., 2007; Zimmerman et al., 2005), and 8.5–20.0% in outpatient private practice (Westen & Arkowtiz-Westen, 1998; Doidge et al., 2002; DiGiuseppe et al., 1995).

One factor that may account for the discrepancies between the rate of NPD diagnoses gleaned from community studies and those reported by clinicians is the nature of assessment of narcissistic pathology. First, most existing assessment instruments used in large-scale research are tied to DSM criteria that privilege the overt grandiose dimensions of the disorder, such as arrogance, entitlement, and admiration seeking, and underplay the vulnerable aspects of narcissistic pathology, including hypersensitivity and emotional reactivity. The latter have been associated with clinical levels of distress and seeking therapy (Ellison et al., 2013), so that clinicians are likely to see those with narcissistic pathology when they are in a vulnerable state of mind. In addition, clinicians may conceptualize pathological narcissism dynamically as a disorder in which pathological grandiose features vie with regulatory impairments that catalyze vulnerable states of distress, shame, and self-doubt. Nonetheless, the high rates of comorbidity suggest that further investigation is warranted on how pathological narcissism may present differently in the context of other co-occurring disorders.



## Functional Impairments Associated with NPD

Although they may be asymptomatic for periods of time and appear to have a good superficial social and occupational adjustment, individuals with narcissistic disorder have significant impairments in the spheres of

love, work, and social life. In fact, individuals with narcissistic pathology are more likely to be divorced or unemployed, which may make them vulnerable to the emergence of more overt symptoms (Ronningstam, 2011; Stinson et al., 2008). In other words, when the individual's characteristic narcissistic defenses (of denial, projection, devaluation, idealization, and retreat into autistic [grandiose] fantasy, see chapter 2) are challenged by life's vicissitudes, they often become highly symptomatic, presenting for therapy with co-occurring mood disorders (depression, bipolar disorders), anxiety disorders, other personality disorders, substance abuse, and suicidality (Stinson et al., 2008; Ronningstam & Maltsberger, 1998; Ronningstam, 2009, 2010, 2013). In fact, narcissistic individuals have been shown to have excessive psychophysiological reactivity (e.g., elevated cortisol, cardiovascular reactivity) in response to everyday negative emotions (Edelstein, Yim, & Quas, 2010; Cheng, Tracy, & Miller, 2013; Kelsey, Ornduff, Reiff, & Arthur, 2002) and in response to imagined experiences of rejection (Sommer, Kirkland, Newman, Estrella, & Andreassi, 2009). Even under conditions of low threat, they show higher levels of stress hormones than individuals who are rated low on narcissism (Reinhard, Konrath, Lopez, & Cameron, 2012), even though those who self-report high on narcissism also report feeling less stress and/or more competence in stressful situations. Based on these and other findings we might surmise that those with pathological narcissism are vulnerable to stress reactions and somatic disorders. Thus NPD indivduals may have painful or frightening internal experiences of which they may or may not be fully aware or able to share, and this compromised internal processing may in fact cause pain and suffering in others. Interestingly, it has been noted that individuals with NPD are distinguished from those with other personality disorders by their proclivity to generate distress in significant others (Miller, Campbell, & Pilkonis, 2007). Thus, narcissistic disorder takes a toll on self *and* others, and it is often the partners, parents, children, or coworkers who precipitate the crisis that brings an individual to treatment.

Given these characteristics, it is not surprising that individuals with narcissistic disorder often generate intense countertransference pressures that may interfere with therapists' observational and analytic functions. One survey of countertransference reactions of psychologists and psychiatrists working with narcissistic patients found that "clinicians reported feeling anger, resentment and dread in working with patients with NPD; feeling devalued and criticized by the patient, and finding themselves distracted, avoidant and wishing to terminate the treatment" (Betan et al., 2005, p. 894). However, we have also experienced and encountered in our colleagues the opposite extreme, in that clinicians report being overinvolved and even fascinated or captivated by individuals with

pathological narcissism, leading to subtle to overt enactments or difficulties with maintaining boundaries (Luchner, 2013).

## TFP for Pathological Narcissism: Translation of Object Relations Theory into Practice

The contemporary object relations perspective presented above has been translated into a treatment approach. TFP is a manualized psychoanalytically oriented, evidence-based therapy designed to treat personality disorders, including NPD (Yeomans et al., 2015). It is most typically a twice-weekly psychotherapy.

TFP for pathological narcissism and NPD (TFP-N) is uniquely suited to treat a spectrum of patients with pathological narcissism with different levels of personality organization from higher to lower functioning, with diverse presentations and levels of severity. Since TFP emphasizes identifying the totality of the individual's internal dyadic experience (e.g., grandiose self, devalued other; vulnerable self, idealized other), it is effective in addressing the different phenotypic presentations, forms of expression, and/or fluctuating mental states that may characterize those with narcissistic pathology across the spectrum of personality functioning.

The major goal of TFP-N with patients with pathological narcissism is to promote modulation and integration of the highly contradictory, distorted idealized and devalued representations that comprise the grandiose self and that underlie so many of the maladaptive patterns in self and interpersonal functioning that we observe as clinicians. Change in these structures over the course of treatment would include the narcissistic individual's increased capacity to recognize, modulate, and integrate the rigidly held idealized and devalued representations of self and others that comprise the grandiose self, and to understand how they have distorted aspects of self and interpersonal experience. These distortions include limitations in the capacity to love; an inability to connect with others beyond the instrumental functions they serve or the adulation they provide; the sense of insularity, emotional isolation, and inauthenticity; and the tortuous strivings for perfection—all of which are often the source of the narcissistic person's suffering. As the compensatory functions of the grandiose self are explored and it begins to dissolve, there is a shift to the capacity to invest in and sustain object relations in depth and also a shift from primitive defenses based on splitting and projection to a more mature defensive system that allows for a successful balance between gratifying one's needs and desires while adapting to the complexity of reality.

The specific tactics and techniques of TFP, modified for narcissistic disorder, are presented in Chapters 4–9. Two features distinguish TFP from other psychoanalytic therapies. The first is prioritizing a focus on the interaction in the session covering the content of the patient's discourse. The second is the dual focus on internal and external reality, and the integration of aspects of external reality into the ongoing transference work.

Each patient is unique, and each therapist is unique, unable to separate his or her subjectivity, personal clinical influences, tolerances, and temperament from the implementation of TFP-N. Each patient brings his or her specific challenges to the treatment frame, his or her particular ways of acting out and of challenging the therapist in the treatment process, and his or her particular defensive signature (Kernberg, Diamond, Yeomans, Clarkin, & Levy, 2008; Yeomans & Diamond, 2010). Furthermore, each patient reacts differently to the therapist's personal style as he or she implements TFP-N. Through this interface of patient and therapist, no two TFP treatments can feel or look exactly the same—however, each clinician can follow what we feel to be the best practices that we distilled from our years of work with narcissistic patients.



## Research Evidence for TFP

TFP has been shown to be an effective treatment for BPD in one uncontrolled study (Clarkin et al., 2001) and two RCTs (Clarkin et al., 2007; Doering et al., 2010). Like several other structured treatments for personality disorders, TFP has been found to foster changes in symptoms (depression, anxiety), psychosocial functioning, impulsive aggression (Clarkin et al., 2007), suicidal and self-injurious behaviors, and service utilization (emergency room visits, hospitalizations; Clarkin et al., 2001; Doering et al., 2010). However, in our studies, only TFP has been shown to be effective in improving the security of attachment representations and the capacity for mentalization, both of which are thought to be indicators of structural change in levels of personality organization (Fonagy, Gergely, Jurist, & Target, 2002; George, Kaplan, & Main, 1996; Levy et al., 2006; Buchheim et al., 2017). After 1 year of TFP, patients have shown shifts from insecure to secure (Levy et al., 2006) and from disorganized to organized attachment representations (Buchheim et al., 2017).

In addition, improvements in reflective functioning (RF; Fonagy, Steele, Steele, & Target, 1998), or the capacity for mentalization in the context of attachment relationships, were also found in two RCTs (Fischer-Kern et al., 2015; Levy et al., 2006). Changes in mentalization

and in the internal working models of attachment relationships are particularly important for patients with pathological narcissism or NPD. Those with pathological narcissism have been found in many empirical and clinical investigations to have difficulty with forming and sustaining attachments and with reflecting on and differentiating between their own and others' mental states—both sequelae of their limited capacity for empathy. TFP is now considered an evidence-based therapy by Division 12 (Society of Clinical Psychology) of the American Psychological Association (*www.div12.org/treatment/transference-focused-therapy-for-borderline-personality-disorder*). It is notable that the research studies described above have included a number of patients with NPD/BPD, from 10% (Doering et al., 2010) to 17% (Clarkin et al., 2007) to 70% (Clarkin et al., 2001).

Recently, we expanded our understanding of NPD through in-depth investigation of the clinical process and outcome of patients with NPD/BPD, and how they differ from those with BPD alone. We also conducted empirical research that shows differential patterns of attachment and mentalization, and how they change over the course of TFP in patients with NPD/BPD (Diamond, Clarkin, et al., 2014; Diamond, Levy, et al., 2014; Hörz-Sagstetter et al., 2018). Inspired by these clinical and research investigations, we adapted the tactics and techniques of TFP with specific modifications for patients with pathological narcissism and NPD. The goal is to refine TFP techniques to address the particular clinical challenges posed by this group of patients, including their high rates of dropout, dismissing devaluation and/or idealization in relationship to the therapist who is enlisted as a mirror or sounding board, and their intolerance of dependency and fear of exposure. All of the foregoing may curtail the engagement with the therapist and contour the nature of transference, as well as the therapist's countertransference, which as noted earlier may range from inordinate pleasure in the patient's idealization and/or to anger and dread in the face of the patient's dismissing devaluation of the therapist, leading to retaliation, detachment, and/or overinvolvement (Betan et al., 2005; Russ et al., 2008). Interestingly, a recent study (Levy, Kivity, Diamond, Kernberg, & Clarkin, 2018) showed that a higher level of narcissism assessed dimensionally predicted both lower rates of dropout and longer time to dropout in patients in TFP, but not in dialectical behavior therapy (DBT) or supportive psychodynamic therapy in the New York–Cornell RCT. Thus, in TFP only, patients with a high level of narcissism (but not those with low levels of narcissism) were significantly less likely to drop out (13%, as compared to 33% for the latter group, which is comparable to ordinary rates of dropout for those with BPD). In addition, in

the same study we found lower rates of dropout in patients with DSM-IV/-5 NPD/BPD diagnoses relative to those with a BPD diagnosis alone (Diamond & Hörz-Sagstetter, 2012). These findings have encouraged clinical researchers at the PDI to extrapolate and refine the empirically supported treatment of TFP for the near-neighbor disorder, NPD.

This book provides a clinical guide that elaborates specific tactics and techniques for patients with narcissistic disorder at different levels of severity and with different presentations. The effectiveness of TFP for patients with BPD, including a number of patients with comorbid NPD, suggests that TFP is an effective treatment for NPD. However, to date there have been no clinical trials for TFP with patients with NPD only, as there have been no clinical trials for NPD individuals in other treatment modalities, such as DBT, mentalization-based therapy (MBT), schema-focused therapy, or short-term dynamic therapy. A first step toward establishing an evidence base for therapy with individuals with pathological narcissism and NPD is thus to further refine our techniques to treat them, and to demonstrate through case material the effectiveness of those techniques. To distinguish our approach from TFP for BPD, we refer to the approach outlined in this book as TFP-N.

## A Look Ahead

In Part I of the book (Chapters 2–4), we outline the object relations model of conceptualizing pathological narcissism and NPD along with research from attachment, cognitive neuropsychology, developmental psychopathology, and social psychology to support it. In Part II (Chapters 5–9), we present how our contemporary object relations model is translated into an approach to assessment and therapy for narcissistic individuals at different levels of organization from high- to low-functioning NPD. Chapter 10 focuses on the theory and treatment of malignant narcissism, the most severe variant of pathological narcissism, and how leaders with this form of narcissistic pathology may extend it into the social and political realms by promising the restoration of supremacy and power at the group level, usually at the expense of out-groups, thereby catalyzing collective narcissism in the citizenry. Finally, since the functional impairments in those with narcissistic pathology are most evident in the sphere of intimate and family relationships, in Chapter 11 we focus on the characteristic difficulties in love relations when one or both members of the couple suffer from pathological narcissism. Chapter 12 provides an overview and summary of the object relations approach to understanding and treating pathological narcissism and NPD.

## Summary and Conclusion

The development and refinement of treatment approaches for a spectrum of individuals with pathological narcissism from low to high functioning is necessary and timely. This is particularly true given the number of individuals both with narcissistic traits that characterize the general population and the prevalence of NPD as a clinically significant personality disorder; the rampant comorbidity of narcissistic pathology with other disorders that may complicate the treatment process; the heterogeneity of patients with narcissistic disorder; and the treatment complications they pose, including high dropout rates, treatment stalemates, and/or maladaptive transference–countertransference patterns. Several studies have established continuity between the characteristics of individuals with narcissistic traits and the more severe impairments of those with NPD; these include impairments in self-esteem and relational difficulties (Miller et al., 2011; Di Pierro et al., 2019; Paris, 2014), and even neurocognitive and neurobiological structures and functions (Fan et al., 2011; Chester, Lynam, Powell, & DeWall, 2016; Schulze et al., 2013). Thus, in the following chapters that delineate our model of theory and treatment, we include clinical and research studies on those with a full NPD diagnosis, as well as those with narcissistic traits. However, we do not believe that narcissistic pathology is the result of pathological amplification (Wright, 2016) of narcissistic traits but rather is distinguished by core structural features involving a particular constellation of idealized self- and object representations. Nonetheless, research investigations that look at narcissistic traits, as well as NPD, are useful to define the full spectrum of narcissistic pathology in its subclinical and clinical aspects. Our goal was to synthesize contemporary object relations perspectives with empirical research from other disciplines in order to develop an understanding of pathological narcissism and NPD that honors its multifaceted nature and presentations, and the challenges of treating those who suffer from it. We hope this clinical guide is useful for clinicians and clinical researchers from a variety of theoretical orientations in understanding the dynamic processes that contribute to the impairments in self and interpersonal functioning, and the symptomatology of narcissistic patients, and will spur them to further reflection and research on the treatment of pathological narcissism.





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