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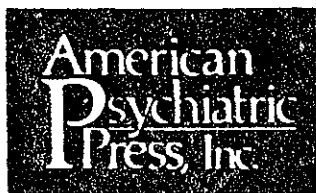
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Chapter 19

Psychotherapy of the Narcissistic
Personality Disorders

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Section

III

Contributions of Self Psychology to Psychotherapy

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Chapter 19

Psychotherapy of the Narcissistic Personality Disorders

by Arthur Malin, M.D.

THE STATUS OF NARCISSISM IN PSYCHIATRIC DIAGNOSIS

The term *narcissism* was introduced into modern psychiatry in 1898 by Havelock Ellis, who used it to characterize what are now regarded as narcissistic perversions. Psychoanalytic interest in narcissism began with Freud's classic paper on the topic in 1914. Freud equated narcissism with self-love, understood in the context of his libido theory. In his classic work, *Character Analysis* (1933), Wilhelm Reich first described certain aspects of narcissistic behavior as manifestations of the resistance associated with character pathology. Four decades later, returning to a more Freudian perspective, Heinz Hartmann (1950) conceptualized narcissism as the "libidinal cathexis . . . of the self" (p. 127).

Psychoanalytic contributions to narcissism as an aspect of character and personality were made during the 1950s and 1960s (Lichtenstein 1964; A. Reich 1953, 1960), but it was only with the detailed descriptions of Heinz Kohut (1968, 1971) and Otto Kernberg (1975) that "narcissistic personality disorder" emerged as a specific diagnostic entity. In "Forms and Transformations of Narcissism" (1966), Kohut proposed that narcissism had a line of development separate from that of object love. In contradistinction to Freud's linear developmental theory, in which autoerotism gave way to narcissism and narcissism, in turn, gave way to libidinal investment in objects (i.e., object love), Kohut proposed that narcissism itself underwent phase-appropriate transformations, beginning with the grandiose self and idealized parental imago of early life and culminating in the mature qualities of humor, wisdom, and empathy. In *The Analysis of the Self* (1971), Kohut took his assumptions about the normal developmental history of narcissism as point of departure for an examination of what he termed *narcissistic personality disorders*.

In parallel with Kohut's efforts to see narcissistic pathology as the outcome of the derailment of early narcissistic development, Kernberg (1975) elaborated ideas about borderline conditions and "pathological narcissism." Although Kernberg attributed to narcissistic personalities many of the same behavioral features as Kohut, he departed from Kohut in his understanding of the genesis of narcissistic disturbances. With Kohut, Kernberg identified as narcissistically disturbed those patients who have a very inflated self-image along with an inordinate need for tribute from others. According to Kernberg:

The main characteristics of these narcissistic personalities are grandiosity, extreme self-centeredness, and a remarkable absence of interest in and empathy for others

in spite of the fact that they are so eager to obtain admiration and approval from other people. These patients experience a remarkably intense envy of other people who seem to have things they do not have or who simply seem to enjoy their lives. These patients not only lack emotional depth and fail to understand complex emotions in other people, but their own feelings lack differentiation, with quick flare-ups and subsequent dispersal of emotion. (Kernberg 1975, p. 228).

Unlike Kohut, however, for whom this behavioral picture pointed to a healthy narcissistic potential arrested at the level of the archaic grandiose self, Kernberg saw the haughtiness, grandiosity, and controlling behavior of such individuals as "a defense against paranoid traits related to the projection of oral rage, which is central in their psychopathology" (1975, p. 228).

Kernberg's depiction of pathological narcissism corresponded with one of two types of narcissistic characters described by Kohut, that is, with the "narcissistic behavior disorders" (Kohut and Wolf 1978) dominated behaviorally by noisy grandiosity and frequently accompanied by addictions, perversions, and hypochondria. Patients with narcissistic behavior disorders loudly proclaim their sense of grandiose entitlement along with their expectation that others acknowledge and defer to it. Such character pathology is to be distinguished from narcissistic *personality* disorders, in which the behavioral picture is dominated by feelings of emptiness, a lack of vitality, and a tendency toward depression.

Self psychology conceptualizes narcissistic behavior disorder in terms of a "vertical split" in the personality: the individual is fully conscious of his feelings of superiority and entitlement, but cannot connect these feelings to the realistic appraisal of his status in the world undertaken by his reality ego. The split is maintained by disavowing the incongruity between the affects attendant to grandiose/exhibitionistic behavior, on the one hand, and to a more realistic understanding of one's place in the world, on the other. A "horizontal split," which presupposes what we regard as a repression barrier, typifies narcissistic personality disorders. Here the archaic narcissistic demands that underlie the patient's low self-esteem, feelings of shame, and propensity for hypochondria are kept out of consciousness. In the self-psychological treatment of narcissistic behavior disorders, the initial goal is to overcome the vertical split so that the repressed narcissistic demands that invariably underlie (and fuel) the patient's "noisy" grandiose shell can be addressed. Once the vertical split is overcome, that is, narcissistic behavior disorders routinely become narcissistic personality disorders. According to Kohut, both subspecies of narcissistic disorder demonstrate similar underlying pathology.

Narcissistic personality disorder entered contemporary psychiatry nosology in 1980 in DSM-III (American Psychiatric Association 1980). Following the revisions introduced in DSM-III-R (American Psychiatric Association 1987; 301.81, p. 351), narcissistic personality disorder is equated, diagnostically, with "a pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation of others, beginning by early adulthood and present in a variety of contexts, as indicated by at least five of the following:

[The patient]

- 1) reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed)
- 2) is interpersonally exploitative: takes advantage of others to achieve his or her own ends

- 3) has a grandiose sense of self-importance, e.g., exaggerates achievements and talents, expects to be noticed as "special" without appropriate achievement
- 4) believes that his or her problems are unique and can be understood only by other special people
- 5) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- 6) has a sense of entitlement: unreasonable expectations of especially favorable treatment, . . .
- 7) requires constant attention and admiration . . .
- 8) lack[s] . . . empathy: inability to recognize and experience how others feel, . . .
- 9) is preoccupied with feelings of envy. (American Psychiatric Association 1987, p. 351)

DIAGNOSTIC CRITERIA ACCORDING TO SELF PSYCHOLOGY

According to Kohut (1971, 1977, 1984), the most reliable diagnostic sign pointing to narcissistic personality disorder is the emergence of a stable narcissistic transference. Such transferences, which revolve around the patient's use of the therapist as a "narcissistic object" or, in Kohut's later vocabulary, a "selfobject," are very unlike the more developmentally advanced "object-libidinal" transferences that typify the oedipal transference neuroses. They likewise differentiate patients with narcissistic personality disorders from those borderline and psychotic patients who cannot develop stable transferences of any type. Since diagnosis hinges on the emergence and consolidation of a genre of transference, it follows, for Kohut, that "the evaluation of a trial analysis is . . . of greater diagnostic and prognostic value than are conclusions derived from the scrutiny of behavioral manifestations and symptoms" (1971, p. 4).

New clinical insight into narcissistic pathology seems to have come by way of, and even to be a byproduct of, a dialogue about the relationship between narcissistic and borderline disturbance. Some contributors (Brandchaft and Stolorow 1984; Stolorow et al. 1987; P. Tolpin 1980) suggest that in certain patients borderline symptoms may yield to the therapist's empathic understanding and engagement of the patient and that, with such understanding, borderline pathology may more closely resemble analyzable narcissistic pathology. In these situations a more stable selfobject transference can develop.

What are the narcissistic or selfobject transferences that emerge in the analysis and analytic psychotherapy of patients with narcissistic personality disorder? A selfobject, according to Kohut, is typically a person (it can also be an inanimate object or an abstract concept) that an individual experiences as part of himself or herself by virtue of the psychological functions that that person (or inanimate object or abstract concept) provides. It follows that all selfobject transferences have in common the patient's use of the therapist as an extension of the self, by which Kohut refers to the therapist's provision of certain self-enhancing and self-regulatory functions (affirmation, admiration, soothing, the provision of feelings of cohesiveness and vitality) that normally belong in the healthy self but that the patient's self, for various reasons, has not achieved.

As a selfobject transference unfolds, the patient comes increasingly to rely on the therapist to provide these essential but missing functions. The predominance of selfobject over oedipal (or "object-libidinal") transference in the treatment of

narcissistic personality disorder refers back to the deficit model of pathology invoked by Kohut to explain such disturbances. Patients suffering from narcissistic pathology present not with primary oedipal conflicts, that is, but with structural, self-related deficits. These deficits are the product of early developmental arrests that precluded maturation along the narcissistic developmental line.

Kohut posits three specific varieties of selfobject transference:

1. The mirror transference, which follows the therapeutic activation of the grandiose self, the most archaic of the normal narcissistic structures. When, in infancy and childhood, the patient's legitimate need (i.e., the need of his or her grandiose self) for mirroring is not met by his or her significant caretakers, this need persists, albeit in a modified form. In analysis or analytic therapy, this thwarted narcissistic need gains expression in a mirroring selfobject transference. The patient, that is, develops the transferential expectation that the therapist will be responsive to him or her and affirming of his or her primitive grandiosity in a way reminiscent of how the patient sought the parents' response in early life.
2. The idealizing transference, which follows from the therapeutic activation of the patient's self-defining and self-sustaining reliance on the idealizable strength and power of the parent, especially the father. The "idealized parental imago," to which the idealizing transference hearkens back, is another archaic structure that is part of normal narcissistic development. In therapy, an idealizing transference indicates the patient's functional reliance on an idealized therapist whose strength and omniscience promote the invigoration of the patient's heretofore enfeebled sense of self.
3. The alter ego or twinship transference, which follows from the therapeutic activation of the patient's need for "the reassuring experience of essential likeness" (Kohut 1984, p. 193) in the guise of alter ego or twinship experiences. Such experiences, once again, are way stations along the path of normal narcissistic development. In therapy, an alter ego or twinship transference is manifest in the patient's need to be similar to, and/or in a colleague-like relationship with, the therapist. Detrick (1985, 1986) has also discussed alter ego transferences.

PSYCHOTHERAPY OF NARCISSISTIC PERSONALITY/ BEHAVIOR DISORDERS

Literature Review

In "The Psychoanalytic Treatment of Narcissistic Personality Disorders: Outline of a Systematic Approach" (1968), Kohut introduced the concept of narcissistic transferences (later the selfobject transferences), of which the mirror and idealizing transferences were the two principal subtypes. It was in this paper as well that he discussed the working-through process in these transferences as well as the countertransference reactions that they typically engendered. In regard to the latter, Kohut observed that when the therapist is treated as a mirroring extension of the patient rather than as an object in his or her own right, the therapist tends to feel disconnected from the patient; this feeling of disconnec-

tion may express itself as sleepiness or a tendency for one's mind to wander. In the idealizing transference, the therapist may feel threatened by, and hence try to deny and debunk, the idealizing demands of the patient.

In *The Analysis of the Self* (1971), Kohut provided a detailed examination of the developmental issues that enter into narcissistic pathology and complicate the treatment of narcissistic personality disorders. The major topics examined in this work include: 1) the archaic narcissistic structures that emerge normally, within the separate line of narcissistic development; 2) the therapeutic activation of selfobject transferences that indicate the original failure of caretakers to respond empathically to the demands encapsulated in the patient's archaic narcissistic structures; 3) the working through of selfobject transferences, centering around the patient's "optimal frustration" with the selfobject therapist and subsequent "transmuting internalization" of the self-affirming and self-regulatory functions that the therapist has come to assume; and 4) the countertransference reactions elicited by the selfobject transferences.

The notions of optimal (selfobject) responsiveness (Bacal 1985), optimal frustration, and transmuting internalization are the keystones of the self-psychological theory of therapy, particularly as it pertains to narcissistic personality disorders. It is the therapist's availability to the patient as a responsive selfobject that permits a selfobject transference to unfold. And it is the patient's psychological dependency on the therapist as a responsive selfobject (i.e., as the self-affirming and self-regulatory part of his or her "self") that signals his or her readiness to be "optimally frustrated" by occasional lapses in the therapist's empathic responsiveness. Finally, it is the therapist's renewed selfobject responsiveness that preserves the self-selfobject bond and imparts the therapeutic leverage for conveying insight into the archaic narcissistic needs that prompt the recurrent episodes of frustration. Out of successive instances of optimal frustration, as understood and explained by the therapist, the patient undergoes "transmuting internalization," i.e., the patient internalizes and in the process makes his or her own (i.e., transmutes) those self-affirming and self-regulatory functions initially vested in the therapist. Optimal frustration, according to Kohut, sets in motion the internalization process that results in renewed growth along the narcissistic line of development. Such growth is tantamount to the creation and consolidation of new self structure. A significant aspect of "cure" is the increased strength of the self structure through transmuting internalization.

Kohut amplified his ideas about the treatment of narcissistic personality disorders in later publications, especially *The Restoration of the Self* (1977) and *How Does Analysis Cure?* (1984). In the latter, posthumously published work he acknowledged that the self-psychological theory of cure made use of a notion of "corrective emotional experience," albeit one dissimilar from that of Franz Alexander. According to Kohut (1984, pp. 78, 153), it is the therapist's optimal frustrations, experienced within the selfobject transference, that are "corrective" in the sense of spurring the creation of the new self structure; such opportunities for structure building "were not forthcoming from the imperfect selfobject responses of early life" (p. 153). (See M. Tolpin [1983] for a further discussion of corrective emotional experience and self psychology.) Contributions by Basch (1980, 1988), Lichtenberg (1987), Paul and Anna Ornstein (1974, 1977, 1982, 1984, 1985), Schwaber (1981), Stolorow et al. (1987), and Wolf (1983, 1988) provide continuing refinement of the self-psychological approach to the treatment of narcissistic

personality disorders. Stolorow and Lachmann (1980), following the emphasis on transdiagnostic "self pathology" in Kohut's later work, have argued that narcissistic disturbances refer not to a discrete diagnostic category, "but rather to a dimension of psychopathology which cuts across all the traditional nosological entities" (p. 23).

The Use of Empathy

What is the route to the selfobject responsiveness that can engage a selfobject transference? What is it about the psychoanalytic *method* that makes such responsiveness possible? In a classic paper of 1959, Kohut argued that empathy, conceptualized as "vicarious introspection," was not only at the heart of the psychoanalytic method, but was also integral to any psychodynamic understanding of the individual. More recently, Basch (1983) has clarified the self-psychological meaning of empathy, explaining, in the spirit of Kohut, that empathy is not tantamount to compassion, but is a mode of inquiry wherein one apprehends, and accepts the subjective validity of, the patient's point of view.

Empathy as a methodological imperative is especially important in psychotherapeutic work with narcissistic personality disorders, since it is just such patients who tax the therapist's capacity for empathic engagement. How do we work with patients who are simply unlikable, voraciously expressing their sense of entitlement, vulnerable to the most negligible slights and perceived insensitivities, prone to withdraw and become inaccessible following the most (seemingly) harmless comments? How, moreover, do we deal with patients who are exploitative in their relationships with others, including their therapists, and who are prone to rage when the therapist fails to comment or interpret in precisely the right way? It is relatively easy to feel ourselves into the state of mind of more likable patients with whom we share common values and a common world view. In working with narcissistic personality disorders, the therapeutic challenge is to empathize with the patient's own difficulty in decentering—of which the therapist's own difficulty in decentering on behalf of the patient functions as a countertransferential analogue—as revelatory of the narcissistic vulnerabilities that he or she brings to the treatment. I am using Piaget's concept of decentering to indicate the ability to limit one's own self-centered (i.e., narcissistic) view of what is going on about him or her (Inhelder and Piaget 1958).

The following vignettes highlight the difficulties in decentering with patients who have narcissistic disturbances, with special reference to aggressive behavior. The self-psychological approach is particularly conducive to the expression of aggression in therapy. In attempting to empathize with the patient's subjective experience, that is, the therapist is thereby encouraging the patient to express a sense of narcissistic entitlement along with the aggressive wishes and fantasies frequently associated with such entitlement. Moreover, since, both genetically and transferentially, self psychology seeks to uncover the narcissistic neediness that underlies such feelings of entitlement, it further mobilizes the patient's exaggerated vulnerability to perceived narcissistic slights. Such vulnerability frequently leads to expressions of narcissistic rage (Kohut 1972); at other times, it simply results in the patient's withdrawal. According to self-psychological theory, such expressions of transferential aggression refer back to early developmental arrests that were the sequelae to unempathic responses to phase-appropriate narcissistic needs on the part of primary caretakers.

Clinical Vignette 1

An exuberant man in his mid-thirties came to me as one of four or five people he had been advised to consider for therapy. In the consultative session, he spoke so continuously that I could say practically nothing. He related his long-standing difficulties with relationships, including problems with parents, siblings, and colleagues in the highly technical field in which he worked. He quickly told me his own therapy-related requirements, including time of day available, desired frequency of visits, and financial arrangements. He confirmed that he had sufficient insurance to cover treatment but added that the financial arrangements might require some allowance on my part—this last being offered as a statement rather than a question.

My only comment was to observe that it seemed very important to this man to have a therapist who understood his special needs. He was very pleased with this remark, though he left reminding me that he would be interviewing other therapists. Several weeks later, he called to announce that I had been "chosen," the clear implication being that I had won a contest of some sort. At the visit that began his treatment, he observed that my almost total silence during the initial consultation had been very important to him; it meant that I was very accepting of everything he said.

In treatment, this man proved to be a difficult personality to treat. His problems at work were obviously connected to narcissistic, exploitative, and exhibitionistic behavior that his colleagues found oppressive. I had to be consciously aware of my own aversion to his behaviors in order to be able to decenter myself and understand his comments from the standpoint of his own subjective experience. I refer, especially, to the authenticity and subjective validity of his affect states (Stolorow et al. 1987, Chapter 5). It was the empathic listening stance, as prescribed by self psychology, that enabled me to remain immersed in the subjective experiences of this difficult patient during the lengthy therapy that ensued.

Clinical Vignette 2

A young man in his twenties, a struggling writer, consulted me because of considerable anxiety and mild obsessive-compulsive symptoms. He was mainly concerned about his difficulty being accepted by people he knew, especially in the context of his work. He was easily upset by the reaction of agents and producers whom he approached with respect to his writing; he fared no better with colleagues with whom he might collaborate. He spoke of his terrible feelings toward his mother, who constantly criticized him and eventually committed suicide when he was 12. His father had discovered the mother's body along with a suicide note, but the patient was only told several years later that her death was due to suicide. The patient remained angry with his deceased mother and had difficulties with his father as well.

In treatment, the patient was preoccupied with getting work in the entertainment industry, and he required that I be completely attuned to the feeling state attendant to his work-related struggles. At one point, when he was describing how difficult it was to get his writing to the people who could evaluate it for use in television, I commented that I had read an article about the large market for script writers of situation comedies—the very type of writing in which the

patient specialized. The patient became visibly upset and said nothing for a minute. He then exploded in rage, telling me that I had no understanding whatsoever of his problem: I was simply telling him what he "should" be doing in ignorance of his repeated protestations that he did not know how to go about doing what appeared to be in his self-interest. His rage was in this instance a justified response to a notably unempathic comment on my part. In fact, his propensity to rage characterized the entire treatment, leading to periodic eruptions that paralleled, transferentially, his rageful reactions in early life to his unempathic mother. His rage on not being adequately understood mirrored his narcissistic vulnerability, whereas his obsessive-compulsive symptoms were attempts to bind anxiety and control the feelings of fragmentation that accompanied frustration and were eventually expressed through the episodes of rage.

Clinical Vignette 3

In supervision, I learned of a patient who had arranged a reduced fee with her therapist, a large part of which was to be paid by her insurance company. A number of months elapsed before the first insurance check arrived, by which time a sizable therapy bill had been run up. At this point, the patient informed her therapist that the insurance check had arrived, but added angrily that she now found the prospect of turning it over to the therapist very disturbing. She wondered why she should do so, seeing that the check was made out to her. She proceeded to argue her case as if the insurance money were not for the therapy she had been receiving, as if it had never been agreed upon that the insurance money would be paid over to the therapist.

The relatively inexperienced therapist under supervision was quite upset by these remarks, but had the good sense to control his exasperation at least until he came for his next supervisory session. The therapist had experienced a narcissistic injury which made it difficult for him to decenter from his own needs, i.e., to get paid for his work. With the supervisory session where his concerns were understood empathically, he could then decenter and reflect on the patient: this exploitative woman, with a profound sense of entitlement, obviously suffered from a narcissistic personality disorder. Engaging the patient empathically, the therapist expressed his understanding of how she might feel cheated at having to hand over money to someone else and of how she might well feel resentful at having to pay someone to help her with her difficulties. Following these and other interpretations informed by the therapist's empathic listening stance, the patient developed a mirror transference that signaled a fuller reliance on the therapist.

Defenses and Resistances

Each of the three preceding vignettes highlights the self-psychological approach to behavior associated with narcissistic personality disorders. From a traditional psychodynamic perspective, the behavior in question would be viewed as defensive; from the self-psychological viewpoint, it is seen as an adaptive response to narcissistic vulnerability (Kohut 1984). According to self psychology, that is, what are traditionally viewed as "defenses" and "resistances" are simultaneously seen to be necessary protective maneuvers to maintain the self at an optimal level of functioning, given its deficits and vulnerabilities. In not confronting the patient with what appears to be resistive behavior, the self-psychological

therapist remains empathically in tune with affective states that accurately reflect the patient's subjective experience. To do otherwise, according to self psychology, is to risk becoming an "external" observer whose comments are tantamount to criticisms of the patient's behavior.

Understanding and Explaining

Kohut's approach to narcissistic personality disorder divides the therapeutic interaction into sequential phases of "understanding" and "explaining." Much of the time, therapy is the attempt to understand the patient, and the therapist must take pains to comment in a way that lets the patient know that he or she is being understood. At times, virtually repeating what the patient has said is the most effective way of conveying this sense of being understood. In his paradigmatic case of Miss F., Kohut (1971) remarked how the patient complained bitterly about his traditional interpretations, only to "become immediately calm and content" when he simply reviewed what she had said during the session (p. 286).

A short time ago, a psychiatrist came for supervision because the patient with whom he was trying to employ a self-psychological approach was becoming increasingly angry. The latter was a woman attorney in her mid-thirties with difficulties in relationships. Whenever the patient described these interpersonal difficulties and her attendant anxiety and depression, the therapist would remark, "I understand." This pattern persisted through a good part of entire sessions, until the patient became quite angry and pronounced the therapy of no help. The psychiatrist, for his part, was quite surprised at this reaction since he believed he had been clearly showing his understanding of her feelings. The problem, of course, is that the simple remark, "I understand," did not convey to the patient what it was that was being understood.

How do we meaningfully convey our understanding of the patient? In certain cases, it requires no more than repeating or reviewing the patient's own comments. More frequently, understanding is conveyed through a comment that connects different aspects of the patient's material in a way that resonates in the therapeutic here and now. Self psychology stresses that understanding is *not* conveyed through theoretical notions that are part of the therapist's lexicon. It is very important not only to stay with the patient's material, but to comment on that material in a way commensurate with the patient's experience, language, and sensibility. With certain patients, connecting material from the current session with material from an earlier session can be disturbing; genetic connections that draw on revelations from previous sessions can be especially stressful. With other patients these connections can be made from the beginning of therapy. In short, the issue of how best to convey understanding is subject to continuing reassessment over the course of therapy; it is always a matter of "where the patient is," experientially and dynamically, at a particular juncture of treatment. Sustained empathic inquiry (Stolorow et al. 1987) by the therapist helps to understand the meaning of the patient's remarks "from a perspective within, rather than outside, the patient's own subjective frame of reference" (Stolorow et al., p. 10). What is essential is that the therapist convey that the patient's reported experience is not only being understood, but is being understood *empathically*, i.e., is being accepted as legitimate and adaptive.

In self-psychological therapy, the "explaining" phase of treatment, which

encompasses interpretations, follows the generally lengthier "understanding" phase. Self-psychological theory, with its emphasis on psychological problems resulting from deficient relationships with early caretakers, tends to explain via dynamic and genetic interpretations. The explaining phase tends to dominate in the later stages of treatment, although the precise relationship between understanding and explaining at any particular juncture of treatment depends entirely on the patient. It should be noted, moreover, that the understanding phase does not summarily end when the explaining phase begins. Rather, understanding and explaining function as relative emphases that recurrently give way to one another as the therapy evolves and the patient's needs and experiences change over time. For a more detailed discussion of this topic see Paul and Anna Ornstein and Ornstein (1985).

CASE MATERIAL: THE SELF-PSYCHOLOGICAL PSYCHOTHERAPY OF NARCISSISTIC PATHOLOGY

Clinical Vignette 4: Narcissistic Behavior Disorder

Mr. M. was referred for treatment because of marital difficulties. He was ashamed that a previous marriage had ended in divorce and that he was now having difficulty in his second marriage. He accused his current wife of not understanding him and of being much more invested in her family of origin than in her marriage. He had had previous therapy and took great pains to get the right referral, interviewing three other therapists before deciding to work with me. My standing in the psychiatric community was very important to him.

A professor at a university, Mr. M. told me of his professional accomplishments. He owned up to exploiting people who could help him achieve his goals, whether academic or financial. He had consciously decided, for example, to become friendly with the chairman of his department in order to get favorable treatment. Likewise, he was friendly with a relative who was involved in real estate foreclosures, hoping to get information that would allow him to buy property at below-market rates. He did not like either of these people, but felt they could be useful to him. With respect to his academic post, he fantasized writing brilliant papers that would enable him to become the head of his department. With respect to his financial aspirations, he fantasized attaining great wealth through real estate investments that were made on the basis of "insider" information. In both areas, he felt entitled to all sorts of special consideration owing to his unique qualities. At the same time, he was unable to empathize with others, especially his wife. He could not discern the motivations of others through their behavior.

From the beginning of treatment, it was important to listen carefully and empathically to Mr. M. and to convey my understanding of his subjective experience. By limiting my interventions to comments that revealed my awareness of his internal state, the therapy progressed to the point that Mr. M. felt relatively safe, secure in the knowledge that I would understand his point of view. At this juncture, a mirror transference developed. Consonant with the affirming, admiring function of a mirroring selfobject, I was required to understand exactly what Mr. M. was experiencing at all times. And consonant with the self-psycho-

logical theory of therapy, Mr. M. was destined to become "optimally frustrated" with my inability to remain unfailingly in tune with him.

Such frustration occasionally followed my requests for clarifying information about his departmental problems at the university. When he expressed concern that one of his academic enemies was a member of the tenure committee then meeting to consider him for tenure, I asked how the tenure committee was constituted, being ignorant of such matters. Following this query, Mr. M. became intensely angry with me, noting, with justification, that *how* the committee was constituted was quite unimportant whereas his feelings *about* the committee and the prospect of his enemy sabotaging the committee's recommendation *were* important.

My response to Mr. M.'s outburst was simply to listen to him as carefully and empathically as I could, trying to understand why this particular request for clarifying information had been so upsetting to him. I did not explore his anger through further questioning. It was enough to listen and eventually convey my understanding of why the matter of tenure was so important to him. Mr. M.'s therapeutic need was for me to be "with him" in his sensitivity to what was transpiring in his department; it was countertherapeutic for me to be concerned with matters that were extraneous to his feeling state.

The outcome of this episode of "optimal frustration" was a renewal of the self-selfobject bond between us. The frustration was "optimal" in the sense that it was not of traumatic proportions and quickly gave way to renewed empathic engagement. Out of this and numerous other instances of empathic lapses on my part, Mr. M. experienced "transmuting internalization": he acquired the ability to regulate tension about important issues in his life, a selfobject function formerly vested in the therapist. The therapeutic yield of these many instances of optimal frustration followed by transmuting internalization was the building up of a cohesive nuclear self.

Clinical Vignette 5: Narcissistic Personality Disorder

Dr. C., a physician in her mid-thirties, came to see me because of major difficulties in her work. She was referred to me by a professor of psychiatry at the distant medical school she had attended. She would not ask anyone in the local area for a referral, as that would be an admission that she needed psychiatric help. She had completed a residency program in which she had never been tested on her knowledge of the field; she had been able to keep to herself. She had never taken her specialty boards out of fear of failing. Now working in her specialty at a county hospital, she was constantly anxious about her performance, and especially about being found to know so little about her field. She became more anxious still when an opportunity to enter a group practice presented itself; she feared exposure, shame, and humiliation.

Dr. C.'s thin veneer of charm and competence masked very superficial personal relationships. An attractive woman, she saw herself as unattractive and unable to interest a man. Previous relationships with men, which included sexual experiences, had been short-lived and relatively unsatisfying. At work, she was prone to depression following questions that might reveal her incompetence. When a nurse questioned her about a medication order, for example, she would become terrified about whether she had prescribed correctly. Overall, she appeared as an unhappy woman whose empty depression, lack of vitality, feelings of

inadequacy, and feelings of fragmentation on being found out as incompetent all pointed to the diagnosis of narcissistic personality disorder. She displayed none of the noisy grandiosity associated with narcissistic behavior disorders.

With empathic listening and simple comments intended to convey understanding of her complaints and feelings, Dr. C. developed an idealizing transference; she perceived me as the all-knowing mentor who, by understanding her, could give her what she needed to develop personally and professionally. She delighted to be in my presence and seized on my every remark as revealing amazing insight. In accord with self-psychological theory, I did not see this patient's need to idealize as defensive, but rather as the therapeutic expression of an aspect of normal narcissistic development. The idealizing transference, which was not actively fostered but simply allowed to unfold, was adaptive because it indicated the resumption of Dr. C.'s narcissistic maturation from the point in early development at which it had been arrested.

In accordance with the development of a full-blown idealizing transference, it was some time before Dr. C. experienced those selfobject failures on my part that, via transmuting internalization, would promote her own self development. Eventually, however, occasions arose in which she expressed her disappointment with me: occasional lateness for a session, weekend breaks, the announcement of an upcoming vacation, and so forth. In all such instances, I took pains not to challenge her interpretation of events; rather I acknowledged the genuineness of her disappointment in me and broached the possible origins of this feeling. It was in the context of these episodes of optimal frustration, that is, that understanding began to give way to explaining, here in the guise of genetic and dynamic interpretations.

One example of the type of optimal frustrations that facilitated the development of Dr. C.'s self-regulatory functions may stand for innumerable others. At one juncture of treatment, my impending 1-week vacation coincided with a period in which Dr. C. was dating a man very interested in her and in whom she, in turn, was very interested. Shaky about this relationship, Dr. C. requested extra sessions for the very week I would be away, even though she had known of the forthcoming interruption for the past several weeks.

Dr. C. was clearly quite upset about my "abandoning" her. In this instance, it sufficed to offer the interpretation that, understandably concerned about her new relationship, she especially needed my supportive presence along with the reassuring stability that therapy imparted to her life. I added that her angry disappointment in me hearkened back to the many times when, as a child, she felt her mother failed her by being preoccupied with her own needs and ignoring the needs of Dr. C., her daughter. These interpretations calmed Dr. C. so that, during my vacation, she was able to calm herself tolerably well. Over the course of many comparably well-negotiated instances of optimal frustration, which collectively added up to the working through of her idealizing selfobject transference, Dr. C. consolidated sufficient new self structure to enable her to make significant gains in both her professional work and her personal life.

SUMMARY

In this chapter I have discussed the status of narcissism and narcissistic personality disorder in psychiatric diagnosis. The criteria for the diagnosis in

DSM-III-R were reviewed. The diagnostic criteria according to self psychology were then described, which emphasized the development of a selfobject transference in the psychotherapy rather than any particular behavioral manifestations. The concepts of the selfobject and selfobject transference (mirroring, idealizing, and alter ego) were examined. Narcissistic behavior disorder was described as a variant of narcissistic personality disorder.

In discussing the psychotherapy of narcissistic personality and behavior disorders the original contributions of Heinz Kohut were reviewed and more recent work by others was cited. Optimal responsiveness, optimal frustration, transmuting internalization, and creation and consolidation of self structure were described as major elements in the self-psychological theory of therapy. The central importance of empathy as the mode of inquiry into the subjective experience of the patient was examined. The self-psychological understanding of aggression and rage as a reaction to frustration from empathic failure, as well as the view of defenses and resistances as protective maneuvers to maintain the self, was described. There was a discussion of the importance of understanding and explaining as phases of interventions or interpretations. Clinical material was offered to illustrate the concepts discussed.

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