THE MANAGEMENT OF NARCISSISTIC VULNERABILITY: THREE CASE STUDIES GUIDED BY STEPHEN MITCHELL'S INTEGRATED TREATMENT MODEL

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ABSTRACT

The psychological literature pertaining to the treatment of the patient with a narcissistic personality disturbance is dominated by the divergent theories of Otto Kernberg and Heinz Kohut. In this context, Stephen Mitchell's theory of narcissistic illusion, which integrates Kernberg's view of narcissism as a defensive phenomenon and Kohut's view of narcissism as a growth-enhancing opportunity, is first reviewed. The current study then seeks to assess, through the application of Mitchell's integrated treatment model to three long-term psychotherapy cases, the efficacy of Mitchell's model. Efficacy is assessed through a comparison of pre-treatment and post-treatment, standardized, self-report measures, including Raskin and Terry's Narcissistic Personality Inventory and the Millon Clinical Multiaxial Inventory-III, as well as by Fishman's individual-case-comparison method. In interpreting the findings of the case studies, I argue that the goal of treatment of patients with a narcissistic personality disturbance is to help them (a) acknowledge their narcissistic orientation, and (b) ultimately understand the function of their narcissistic illusion. I conclude that Mitchell's theory successfully guides the clinician to such an outcome. The strengths and limitations of Mitchell's model are critically reviewed. Finally, adjunctive interventions to aid the clinician in the management of the patient's ongoing narcissistic vulnerability are proposed.

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The Treatment of Narcissistic Personality Disturbances

The psychological literature includes a wealth of contributions that address the hypothesized etiology of narcissism (see, e.g., Miller, 1981), the varied clinical presentation of narcissistic patients (see, e.g., Gabbard, 1989), and the leading theoretical models for the treatment of individuals with pathological narcissism (Kernberg, 1975, 1984; Kohut, 1971, 1977, 1984; and Masterson, 1988, 1989, 1995). In addition, the literature includes a number of empirical studies on narcissism which enhance our understanding of such issues as the comorbidity of narcissism with Axis I disorders and its long-term stability (Ronningstam, 1998, 2005). Yet, despite the breadth of the current literature, there are few examples that consider in detail the actual long-term treatment of an individual with a narcissistic personality disturbance, and, in doing so, articulate realistic therapeutic outcomes for the narcissistic patient as well as concrete therapeutic interventions for the attainment of such outcomes.

The theories of Heinz Kohut and Otto Kernberg dominate the literature with respect to the treatment of the narcissistic patient. Yet, these theories stand at odds with one another and leave the clinician puzzling over the appropriate technique when addressing the struggles of the narcissistic patient. Further, beyond such foundational theories, several practical questions remain with respect to the treatment of the narcissist. For instance, when working with a narcissistic patient, is the ultimate goal of treatment to have the patient acknowledge his narcissistic tendencies and, if so, to then work to renounce this orientation? Given the fragile nature of the narcissistic personality structure, is such an overt acknowledgment by the patient advisable? If so, would a full renunciation then be a realistic goal or is the patient always going to struggle with a narcissistic personality organization? If a restructuring of the patient's

personality organization is not a realistic outcome, what interventions exist to best assist the patient as he tries to negotiate the world through a narcissistic lens?

In pursuit of answers to such questions, this project seeks to detail, through the use of case studies, certain highlights of the psychodynamic treatment of three individual patients, each of whom presented to treatment with a narcissistic personality disturbance, as defined below, and was treated by this author. Through a review of certain aspects of the treatment of these individuals, with a particular emphasis on the later stages of treatment, it is hoped that this project will illuminate more thoughtful ways to work with the narcissistic patient. First, guided by the work of Stephen Mitchell (1988), one of the leading theorists in the relational school, this project seeks to detail the application of his integrated relational approach to the treatment of patients with a narcissistic personality disturbance and employs the concept of a *narcissistic integration*. Hereafter, Mitchell's integrated relational approach, which synthesizes the work of Kernberg and Kohut, will be referred to as his *integrated treatment model*. Second, this project seeks to take a step beyond Mitchell's model and to offer original contributions concerning the ongoing management of the patient's narcissistic vulnerability. The efficacy of Mitchell's integrated treatment model as well as this author's original contributions will be assessed using Fishman's case study method (1999).

Two of the three patients discussed herein meet the criteria for Narcissistic Personality Disorder as set forth in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) (American Psychiatric Association, 2000). *Narcissistic Personality Disorder* is a psychological diagnostic category defined in the DSM as a personality style characterized by a pervasive pattern of grandiosity (in fantasy and/or behavior), a need for admiration, and lack of

empathy, which result in impairments in the individual's personal functioning and interpersonal relationships. Specifically, an individual with Narcissistic Personality Disorder may evidence: (a) a grandiose sense of self-importance (for instance, he may exaggerate his achievements and talents), (b) a preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love, (c) a belief that he is "special" and unique and can only be understood by, or should associate with, other special or high-status people or institutions, (d) a need for excessive admiration, (e) a sense of entitlement (for instance, he may have unreasonable expectations of favorable treatment or automatic compliance with his expectations), (f) behavior that is interpersonally exploitative (for instance, he may takes advantage of others to advance his own ends), (g) a lack of empathy (in other words, he may be unwilling to recognize or identify with the feelings and needs of others), (h) envy of others or the belief that others are envious of him, and/or (i) arrogant behaviors or attitudes.

Also, all three of the patients discussed herein can be said to suffer primarily from a *narcissistic personality disturbance*. As defined, this construct is broader in scope than the DSM's view of narcissism as set forth in the diagnostic category of Narcissistic Personality Disorder; and, as such, this construct captures individuals who present with a variety of narcissistic styles, as addressed below. An individual who suffers from a narcissistic personality disturbance evidences a characterological disturbance in which the patient's social functioning is impaired as the result of an overreliance on the use of grandiosity and/or idealization in order to avoid the affects of shame and depression as well as a longing for dependency. The patient with a narcissistic personality disturbance suffers from a fragility of character due to an uncertainty in his sense of self and, as a result, he often feels chronically empty and/or disappointed with

significant aspects of his life. He is prone to the narcissistic injuries of feeling slighted, ignored or treated without respect, and, as a result, may react with rage in the context of a sense of grandiosity/entitlement or depressive withdrawal (Mollon, 1994). With this in mind, broadly speaking, the major domains in which the therapist seeks to intervene in the treatment of an individual with a narcissistic personality disturbance are the patient's (a) grandiosity, whether overt or covert, (b) tendency to idealize/devalue others, and/or (c) counterdependency, in each case so as to access and explore the underlying affects of shame and depression. Through such focus, and the eventual emergence of the patient's underlying affects, it is hoped that the patient's more genuine self can emerge. As the patient pursues more realistic goals and interests, it is hoped that his chronic feelings of emptiness and/or disappointment will abate.

For convenience, this paper will make use of the male pronoun when referring generally to a patient who suffers from a narcissistic personality disturbance. The material discussed herein is equally applicable to female patients.

Case Context and Method

The Rationale for Selecting the Patients for this Study

It is well-documented that there are different presentations of narcissism. A review of the literature finds a discussion of: *thick versus thin-skinned narcissists* (Rosenfeld, 1987), *oblivious versus hypervigilant narcissists* (Gabbard, 1989), *arrogant/entitled versus depressed/depleted narcissists* (PDM Task Force, 2006*), overt versus covert narcissists* (Akhtar, 1989), *overt versus shy narcissists* (Cooper & Ronningstam, 1992), as well as *compensatory, amorous, elitist and unprincipled narcissists* (Millon, Grossman, Millon, Meagher & Ramnath, 2000), and *craving,*

paranoid, manipulative and phallic narcissists (Burstein, 1973). While commentators have proposed various names the differing presentation of the narcissistic patient, there appear to be two main types of narcissistic presentation. For the purposes of this project, I will use the terms *entitled narcissist* and *depleted narcissist*, as these labels seem to capture with accuracy the central underlying issues with which the patients in this study struggled. The entitled narcissist is characterized by his overt sense of entitlement and his chronic devaluation of others. The depleted narcissist is characterized by his use of idealization, his sycophantic nature, his chronic envy and his proneness to becoming depressed in the face of slights. As McWilliams (1994) and Holmes (2001) note, these labels are not mutually exclusive; rather, a given patient may possess features of both the entitled and depleted narcissist.

Further, as McWilliams (1994) notes, there is no consensus among clinicians as to the most efficacious way to treat narcissistic patients. McWilliams writes that, among her peers, there is an understanding that some patients are more responsive to the interventions proposed by Kernberg while others are more responsive to the interventions set forth by Kohut. Broadly speaking, it is held that entitled narcissists benefit most from the interventions proposed by Kernberg while depleted narcissists benefit most from the empathic immersion proposed by Kohut. Stated differently, the clinician often selects an intervention model based on the patient's ability to tolerate the shame underlying his narcissism; entitled narcissists can often tolerate Kernberg's more confrontational style whereas the depleted narcissist would likely flee from treatment if his shame were prematurely uncovered (Morrison, 1989).

Finally, it is well-documented that the treatment of narcissistic patients is notoriously difficult. From issues of ego fragility to negative countertransferences, much of the literature

warns the clinician about the perils of the treatment of a patient with a narcissist personality disturbance. A great deal of the peril lies in the selection, timing and delivery of the appropriate technique. Masterson (1988) writes:

> Therapy with [individuals with] narcissistic personality disorders brings to mind procedures necessary to allow an orbiting space capsule to reenter the earth's atmosphere. The capsule must be set at the right angle and the right speed at the appropriate time in order for it to leave the orbit and reenter. If any of the procedures are inappropriate, the capsule with not reenter but "skip off" into outer space. In an analogous fashion, the [patient with a] narcissistic personality disorder requires carefully timed interpretation of his or her narcissistic vulnerability in order to give up the self-defeating orbit of defenses… Inappropriate timing or technique will cause the psychotherapy to fail, and the patient will not reenter the world of [exploration] but remain locked in the orbit of self-defeating defenses. (p. 189-190)

With the foregoing in mind, I selected three patients with dissimilar presentations in order to test whether Mitchell's integrated treatment model had broad applicability to both entitled and depleted narcissists as well as the flexibility to address a myriad of potential problems that seem to be common occurrences in the treatment of patients with a narcissistic personality disturbance. For these case studies, I selected: first, a male patient with an entitled narcissistic presentation; second, a male patient with a depleted narcissistic presentation; and, third, a female patient who exhibited from session to session either an entitled narcissistic presentation or a depleted narcissistic presentation. These patients were selected for consideration because their presenting issue was a narcissistic personality disturbance, and its treatment was not complicated by other comorbid disorders. As McWilliams (1994) notes, the narcissistic patient rarely presents to treatment with the request to become a better-related person, such as a more attentive boyfriend. Rather, the patients all presented to treatment with feelings of emptiness, an inability to access a sense of passion, and/or a chronic sense of disappointment in the significant individuals in their lives.

The Methodological Strategies Employed for Enhancing the Rigor of the Study

In order to enhance the rigor of the study, the patients were not sought out for inclusion in this project. Rather, the patients presented for treatment to the clinic (as discussed below), were randomly assigned to this author, and were in the normal course of treatment assessed, through clinical interviewing and then assessment tools (as discussed below), as suffering primarily from a narcissistic personality disturbance.

Once deemed suitable for this project, each patient was then formally invited to participate in a study concerning the efficacy of certain treatment models for patients with issues of self-esteem regulation. Each patient agreed to participate by signing an informed consent. In those instances in which a patient consented to inclusion in the study, the patient was then administered, after the initial intake session, the Narcissistic Personality Inventory (NPI) (Raskin & Terry, 1988) in order to assess if the patient suffered from a narcissistic personality disturbance. Each participant in the study agreed to take this measure again at the end of therapy (in order to assess whether there were any changes in his or her narcissistic personality organization when compared to the beginning-of-therapy scores).

The NPI is a 40-item forced-choice assessment tool based on the DSM-III clinical criteria for Narcissistic Personality Disorder that seeks to measure individual differences in narcissism. Raskin and Terry (1988) identified seven factors underlying the multidimensionality of the narcissistic phenomenon, including superiority, exhibitionism, entitlement, vanity, authority, exploitativeness and self-sufficiency. Studies conducted by the authors have offered support for the internal consistency and construct validity of the full-scale NPI and its component scales. The NPI measures subclinical narcissism; individuals who score very high on the NPI do not

necessarily meet criteria for diagnosis of Narcissistic Personality Disorder. Rather, one can argue that these individuals can be said to have a character structure with narcissistic features and to struggle with those characterological issues most frequently encountered by such individuals.

Then, each patient was given the Millon Clinical Multiaxial Inventory-III (MCMI-III)(Millon, Davis & Millon, 1997) in order to further assess if he or she suffered from a narcissistic personality disturbance. Each participant in the study agreed to take this measure again at the end of therapy (in order to assess whether there were any changes in his or her narcissistic personality organization when compared to the beginning-of-therapy scores).

The MCMI-III is a 175-question self-report inventory designed to assess personality disorders, including Narcissistic Personality Disorder. In particular, the instrument measures the test taker's personality style on 15 scales, including a narcissism scale (as defined in accordance with the DSM-III definition of Narcissistic Personality Disorder). The measure has been shown to meet psychometric standards for reliability and validity (Archer & Smith, 2008**)**.

Finally, each patient was then administered the Personality Assessment Inventory (Morey, 1991) (PAI) in order to further assess if the patient suffered from a narcissistic personality disturbance. This measure was administered only at the beginning of treatment in order to gain additional certainty that the patients suffered from a narcissistic personality disturbance.

The PAI is a 344-question self-report inventory designed to provide the clinician with information concerning clinical diagnosis and screening for psychopathology, including

Narcissistic Personality Disorder. The test items comprise 22 non-overlapping scales: 4 for validity, 11 for clinic diagnoses, 5 for treatment considerations, and 2 for interpersonal functioning. The measure has been shown to meet psychometric standards for reliability and validity, with a particular strength of content and discriminant validity (Archer & Smith, 2008).

Each instrument was administered in order to assess at the outset of treatment each patient's personality style broadly and to consider their narcissistic traits as compared to their other personality traits. In each case, the patients had elevated self-reported narcissism scores (relative to the general population and/or other clinical scales) and no comorbid Axis I disorders.

Thereafter, a qualitative analysis of the outcome in the three cases was conducted by applying Fishman's (2008) "individual-case-comparison" method to audiotapes, transcripts and process notes of the therapy sessions. Through this type of in-depth comparison of the three case studies, the analysis sought to (a) illuminate the principles of Mitchell's integrated treatment model in practice, (b) demonstrate how the treatment of a patient with a narcissistic personality disturbance progresses under this model, (c) parse out the commonalities among the patients under consideration with respect to their narcissistic personality disturbance, and (d) test this author's proposed interventions for the management of the patients' ongoing narcissistic vulnerability.

Each individual treatment session was audiotaped and systematically reviewed with a psychodynamically-oriented case supervisor, each of whom was a licensed clinical psychologist with an average of eleven years of post-doctoral experience. In the course of such supervision, the author presented select portions of each session, or process notes of such session, to the

supervisor on a weekly basis. Each session was then recorded over with the following session; this process of analysis by the author and each respective supervisor continued for the duration of each treatment. In select cases, portions of a given session were transcribed for inclusion herein. The patient narratives set forth below were presented to their respective supervisors and, in each case, the supervisor found the narrative consistent with the case as discussed.

Within the context of knowing that the present research will involve only three patients and thus generalization is substantially limited, the qualitative results of the research will be employed to develop tentative guidelines to help other therapists: (a) assess whether Mitchell's integrated model yields benefits different from the individual models proposed by each Kohut and Kernberg; (b) to identify those factors in Mitchell's model that appear most efficacious, and (c) to appraise the utility of this author's contributions as an adjunct to Mitchell's integrated treatment model.

The Clinical Setting in Which the Cases Took Place

The two male patients detailed in this case study were seen by this author once a week in outpatient therapy. The female patient was seen by this author twice a week in outpatient therapy. The outpatient clinic was affiliated with a major U.S. university; the clinic was staffed with students pursuing doctorates in clinical psychology. Fees were established on sliding scale.

Sources of Data Available Concerning the Patients

No data were available on the patients outside of the standard referral and therapy processes. Of the three patients, only the female patient detailed in the study consulted with a psychiatrist for medication management; she did so after commencing treatment with this

therapist. Because none of the patients had previously been in treatment, no prior reports or consultation sources were available.

Confidentiality

For the purposes of confidentiality and convenience, the names of all individuals referred to herein have been changed, along with certain non-material details.

The Patients

The first patient, Alex, was treated by this author weekly for 19 months, for a total of 68 sessions. Alex was a 30-year-old Caucasian heterosexual male, who presented for treatment with feelings of discontent in the context of his realization that his rock band, of which he was the lead guitar player for over a decade, may not become commercially successful. At the outset of the study, Alex met full DSM-IV criteria for Narcissistic Personality Disorder, and he will serve as an example herein of an entitled narcissist. Both in session and in the world, Alex was prone to expressly assert his superiority to others and to wonder openly and without reticence how other people seemed to be more happy and successful than he even though he possessed a superior intellect, more attractive physical appearance, and unique skills. Alex had a boyish appearance, including long hair and a slight build. In most cases, he came to session dressed in a t-shirt and jeans. Alex presented with a need to find a wise other with whom to ally and from whom he could learn. To this end, the early treatment of Alex focused on his use of an idealizing transference.

The second patient, Brian, was treated by this author weekly for 24 months, for a total of 92 sessions. Brian was a 19-year-old Caucasian homosexual male, who presented for treatment with vague depressive symptoms in the context of his realization that he was not having the college experience that he had dreamt of as a youngster. At the outset of the study, Brian did not meet full DSM-IV criteria for Narcissistic Personality Disorder. Regardless, Brian struggled with a narcissistic personality disturbance, and he will serve herein as an example a depleted narcissist. Whether in session or in the world, Brian had a difficult time owning his grandiosity and always felt far more comfortable allying himself with "cool people" so that he could bask in the glow of their perceived excellence. Brian was not a classically handsome man. He held the belief, however, that he was very attractive, and he regarded himself as an excellent dresser. Brian presented with significant identity diffusion and a clear deficit in his ability to identify his own interests and desires. With this in mind, the early treatment of Brian focused on his use of a mirroring transference.

The third patient, Candace, was treated by this author twice a week for 11 months, for a total of 83 sessions. Candace was a 26-year-old heterosexual Japanese-American female, who presented with depressive symptoms in the context of a work-related crisis. Candace loathed her job; however, in view of its prestige, she felt stuck and unable to reconcile her strong desire to leave her job with her view that she worked at one of "the best companies in the world." At the outset of the study, Candace met full DSM-IV criteria for Narcissistic Personality Disorder; and, further, she is an example of a narcissist whose presentation alternated between an entitled and depleted narcissistic style. Candace was overweight and had acne. While this author suspected that the patient suffered from self-esteem issues related to her body, the patient never discussed

at length any concerns about her appearance during the course of treatment. In time, Candace admitted in session that she thought frequently about death; at no time during her treatment was she suicidal but, at times, her fantasies contained images of passive suicidality. Candace demonstrated a strong need to ally herself with me in order to reinforce the similarities that she perceived between us. As such, the early treatment of Candace focused on her use of a "twinship" transference.

Guiding Conception with Research Support

Mitchell's Narcissistic Illusion

Mitchell (1988), a relational theorist, expounding on Freud's notion of the illusory quality of narcissistic grandiosity and idealization, reframes the concept of *narcissistic illusion*. According to Mitchell, who draws on the work of several leading psychoanalytic theorists, narcissistic illusions can be either a form of defense or creativity. First, as Kernberg's work suggests, such illusions help the patient to defend against the harshness of his reality by retreating from it. Narcissistic illusions of grandiosity "protect the patient from the dreadful state in which he spent much of the first several years of his life, depending on others for protection and care, yet perpetually dissatisfied, victimized, and enraged." (p. 183). In this case, such illusions remove the potentially painful need to be dependent through the devaluation of others. This system is flawed, however, because such defensive devaluation in turn assures that the individual remains chronically disconnected from and disappointed in others. The illusion, while

perhaps adaptive in childhood, ultimately serves to draw the adult patient away from meaningful and realistic involvement with others.

With the work of Kohut in mind, Mitchell also presents the narcissistic illusion as a form of creativity. For Mitchell, the patient's narcissistic illusion of grandiosity or idealization may represent the patient's attempt to create crucial developmental opportunities, including a self-object relationship unavailable to the patient in childhood. Mitchell, like Kohut, maintains that the patient's development was stalled because the patient's parents failed to furnish him with an opportunity to experience the invigorating delusions of grandeur and idealization. Yet, like the defensive use of narcissistic illusion, the creative use of narcissistic illusion, if not responded to by the therapist, becomes an impediment to the patient's ability to relate meaningfully to others.

While a fully elaborated overview of the work of Kohut and Kernberg is beyond the scope of this paper, one of Mitchell's greatest contributions is his integration of their theories, each in relation to the treatment of narcissism. In order to appreciate Mitchell's integrated theory, a brief overview of the respective theories of Kernberg and Kohut is warranted.

Theories of Kohut and Kernberg

Kohut (1971, 1977, 1984) and Kernberg (1975, 1984) agree that the narcissistic personality is characterized by a pathological grandiose self. The grandiose self promotes the appearance of competence; however, its function is to mask severe fluctuations in the patient's self-esteem, and it may ultimately serve to isolate the patient from meaningful interpersonal connectedness. The grandiose self lacks depth and continuity of experience.

Kohut (1971, 1977) maintains that a narcissistic disturbance can occur as the result of an arrest at one of three phases of normal/healthy infantile narcissism: (a) the grandiose self, during which a parental selfobject -- which refers here to any narcissistic experience in which the parent is used in the service of the child and during which the parent is seen by the child as the structure that accounts for his experience of continuity, coherence, and well-being -- is engaged by the infant to mirror his feelings of omnipotence, (b) the twinship, in which a parental selfobject provides the child with the experience of essential sameness, or (c) the idealized parent imago, in which the infant projects his sense of omnipotence onto an internalized parental selfobject with whom he seeks to merge in order to enhance his feelings of power and competence. In normal development, the infant is able to internalize the functions performed by the parent during this phase. If the need for mirroring, twinship and idealizing are frustrated by the parent, these needs will persist into adulthood, and the individual's struggle to satisfy these needs, or compensate for their absence, will lead to narcissistic pathology. For Kohut, the primary subjective experience of the narcissistic adult is a feeling of emptiness and a lack of vitality.

Kohut, who views the emergence of narcissism as a signal of developmental arrest, felt that each person needed to internalize these skills in childhood in order to retain a sense of vigor in adulthood. If the patient has been developmentally arrested in childhood, he needs the therapist to act as an extension of him in adulthood so as to help him unearth these crucial subjective experiences. The patient signals to the therapist his developmental needs through some variant of a narcissistic transference. These transferences include a mirroring transference, an idealizing transference, and a twinship transference. Kohut held that the interpretation of these transferences in a classic psychoanalytic manner would be shaming to the patient. Rather, he

urged the therapist to let the patient become immersed in the transferences and, in time, the patient's development would restart and his vitality emerge. As a result, the patient is able to develop "a more cohesive, resilient, robust sense of self, capable of enduring disappointments, adjusting to the realities of life, and finding vitalizing pleasure in personal experience" (Mitchell & Black, 1995, p. 161).

McWilliams (1994) notes that narcissistic transferences are special in that, rather than projecting a discrete internal object -- such as a parent -- onto the therapist, the patient externalizes an aspect of himself. For instance, a patient may project the devalued part of himself (e.g., his deflated self and its proneness to negativity) on the therapist. The therapist's job thus becomes to act as a selfobject for the patient in that the therapist becomes a temporary "container for the [patient's] inner process of self-esteem maintenance." (p. 180)

Kernberg (1975) holds that pathological narcissism is different from healthy adult narcissism or a fixation at any stage of infantile narcissism. Further, unlike Kohut, who views the grandiose self as a normal archaic structure that was developmentally arrested, Kernberg views it as a pathological structure that holds a condensed version of the real self, ideal self and ideal object, and maintains that its existence leads to distortions in the formation of both the ego and superego. For Kernberg, the primary subjective experience of the narcissist is one ruled by the aggressive entitlement of the grandiose self.

In his writing, Kernberg stresses the pathological nature of the inner world of the narcissist (Akhtar, 1992). Such pathology is seen in the patient's defective empathy, his extreme contradictions in self-concept, and his incapacity for experiencing mourning, longing, and sadness when faced with separation and loss. Kernberg holds that, although some narcissists

have the capacity for hard work, such work is often exhibitionistic in nature and done primarily for admiration. He further noted that narcissists exhibit a readiness to shift values to gain acceptance by others and a notable deterioration in their capacity for object relations.

According to Kernberg (1984), "the most important aspect of the psychoanalytic treatment of narcissistic personalities is the systematic analysis of the pathological grandiose self, which presents itself pervasively in the transference" (p. 197). The patient's grandiosity is used to avoid the emergence of the repressed and projected aspects of the self. This splitting allows the patient to foster the chronic absence of the real aspects of interpersonal relationships.

Mitchell (1988) addresses the opposing treatment recommendations of Kohut and Kernberg:

> [F]rom Kohut's point of view, the kind of methodical interpretive approach to narcissistic transferences recommended by Kernberg is extremely counterproductive, implying a countertransferential acting out…Kernberg's stance suggests great difficulty in tolerating the position in which the narcissistic transferences place the analyst, arousing anxiety concerning his own grandiosity (in the idealizing transference) or envy of the of the patient's grandiosity (in the mirroring transference). (p. 191)

To Kohut, the methodical interpretation of the transference is experienced by the narcissistically vulnerable patient as an assault that tends to generate intense narcissistic rage in the patient. Conversely, Kernberg would argue that such rage was inherent and long-standing in the patient.

On the other hand, from Kernberg's vantage point, Kohut's approach is "an exercise in futility" as "an unquestioning acceptance of the patient's illusions with the assumption that they will eventually diminish…represents a collusion with the patient's defenses." (p. 191) To Kernberg, such collusion subverts the analytic process, and the analyst renders himself impotent to help the patient change. In essence, Kernberg feels that Kohut's acceptance of the patient's

idealization will inevitably cause the analyst to abandon his position of neutrality and to be drawn into the patient's need for mutual illusion.

Despite their differences, Mitchell cautions that one approach should not be regarded as more empathic than another. Each approach proceeds empathically from a different view of the patient's experience. Mitchell writes:

> Kernberg's narcissist lives in an embattled world, in which he and other others are experienced as sadistic, self-serving and exploitative. The only possible security lies in a devaluation of others, disarming them of their power to hurt him. From this perspective, an empathic response entails an appreciation of his endangered status and a delineation of his narcissistic defenses, along with an effort to make some meaningful contact possible. To simply accept the grandiosity would be to empathize only with the most superficial level of the patient's defenses and not with what is presumed to be his underlying experience.
>
> Kohut's narcissist, on the other hand, is a brittle creature who lives in a harsh and continually bruising world. The only possible security lies in a splitting off of important segments of the self…in an effort to protect the deep and tender feelings connected to them, often covered over by bravado or narcissistic rage. From this perspective, an empathic response entails an appreciation of the continual threat of self-dissolution and disintegration, and an encouragement of growth-enhancing illusions. To challenge the patient's [narcissistic] illusions would be to perpetuate the repeated trauma of childhood. (pp. 192-3)

Mitchell's Integrated Treatment Model

Mitchell notes that in practice it is unlikely that the majority of clinicians rely exclusively on only one of the two sharply different theories; in effect, each clinician struggles to find a midpoint between challenging and accepting the patient's narcissistic illusions. With this in mind, Mitchell offers an integrated relational perspective on the treatment of narcissism. As noted, Kernberg views narcissism as a defensive phenomenon and Kohut views it as a growth-enhancing opportunity. Mitchell, however, asserts that both theorists have failed to appreciate the that the primary function of narcissism throughout the life cycle is *to integrate interpersonal*

relationships and fantasized ties to significant objects; this is accomplished through the patient's use of stereotyped patterns thought to be necessary by the patient in order to maintain such interpersonal relationships and fantasized ties (p. 194).

To Mitchell, the narcissistic integration refers to the patient's attempts to integrate interpersonal relationships, such as a relationship with a therapist, and fantasized ties to significant objects, such as a parent. The current relationship with the therapist will be colored by the illusions that the patient has relied on in the past in order to maintain his relationship with his parent. If, in the past, the parent encouraged the patient's grandiosity (in service of the parent's self-esteem), the patient will likely present such grandiosity to the therapist in the present because the patient feels that such grandiosity is what is required of him in order to maintain the relationship with the therapist. With the foregoing in mind, according to Mitchell, Kernberg has failed to account for how narcissism can serve to secure certain types of developmentally crucial relationships to others; and, Kohut has failed to account for the fact that narcissism can often constrict real engagements, such as honesty between the patient and the therapist.

Rather, Mitchell encourages the clinician to consider how each patient uses his narcissistic illusion(s). The clinician must ask himself: does the patient rigidly use the illusion to deny reality (and proceed unrealistically as if his sandcastle will not be washed away by the inevitable tides)? Or does the patient rigidly use the illusion to avoid reality (and fail to make a sandcastle because, knowing that it will surely be washed away by the tides, he seeks to avoid disappointment)? Or does the patient proceed in a functional manner despite the illusion (building his sandcastle even though he knows that it will be washed away)? Mitchell holds that in order to be able to use illusion adaptively, as noted in the last example, the patient needs to

have received from his parent the ability to play with the illusions of grandiosity and idealization but also to tolerate the deflating disappointments of the realistic limitations of such playful illusions. Mitchell writes, "the ideal parental response is neither a total immersion in illusion nor a cynical rationalism, but a capacity to play with illusions while never losing sight of the fact that [it] is a form of play." (p. 196)

With respect to technique, Mitchell suggests that clinicians view the narcissistic illusion as an invitation. The patient is in effect inviting the therapist to participate in a relationship in the manner most familiar to the patient. Specifically, if grandiosity is involved, an expression of admiration may be requested. Alternatively, if idealization is involved, some acknowledgement of the patient's devotion may be requested. Mitchell writes:

> The most useful response entails a subtle dialectic between joining the [patient] in the narcissistic integration and simultaneously questioning the nature and purpose of the integration, both a playful participation in the [patient's] illusions and a puzzled curiosity about how and why they [became so crucial to the patient's] sense of security and involvement with others." (p. 205).

Further, and in line with the work of Fiscalini (Fiscalini & Grey, 1993), Mitchell appears to be encouraging the therapist not to enter treatment with rigid guidelines in hand but rather to explore with each patient the particular meaning of his narcissism as it emerges and evolves in the course of the treatment. An exploration of what emerges spontaneously in the transference and the therapist's response to such material is more helpful to the patient than the rigid application of the "authoritarian" treatment models of Kernberg and Kohut (p. 319).

Through such mutually curious participation, the therapist may learn, for instance, that those who are grandiose feel that this asymmetrical form of relatedness was the only means of relating in the family when the patient was a child. Likewise, the therapist may learn that those

who engage in idealization view the world as a treacherous place and therefore feel that the most sensible strategy is to ally oneself with an individual perceived to have superior resolve and knowledge (Mitchell, 1988). Overall, with respect to technique, Mitchell maintains that "the [therapist's] participation in the [patient's] illusions is essential to the establishment of the narcissistic integration; the [therapist's] questioning of illusions is essential to the dissolution of this integration and the establishment of a richer form of relation." (p. 234)

Mitchell's integrated model, unlike the individual models of Kernberg and Kohut, allows for both a joining of the patient, via an acceptance of his narcissistic illusions, and the opportunity to challenge the patient's restrictive behavior. The ability to join the patient in his illusions is critical in the development of a therapeutic alliance and in the creation of a place of safety for the patient to explore his dynamics. Yet, at the same time, the ability to challenge the patient is crucial to allowing the patient to come to understand the origin and limitations of his restrictive illusions. Mitchell writes that, "viewing narcissistic illusions as defensive highlights their role in perpetuating internal equilibrium and constriction in living…[while] viewing narcissistic illusions as growth enhancing highlights their potential role in enriching self-experience." (p. 234)

Mitchell's theory raises questions concerning the issue of therapeutic neutrality. Mitchell noted that both Kernberg and Kohut regard themselves as maintaining neutrality and believed that the other's technique inevitably led him to abandon a neutral analytic stance. As a relational theorist, Mitchell asserts that neither was entirely neutral. In order to effectively treat the patient, strict neutrality is not possible because the therapist must join the patient in his illusion. Mitchell writes:

> The most constructive form of analytic participation derives from the discovery of a path between the contrasting dangers of complicity and challenge, a path that reflects a willingness to play, an acceptance of the importance of the narcissistic integration as a special and favored mode of relation, yet also a questioning of why this must be the only way. (p. 207)

Adjunct Interventions

This project entails the application of Mitchell's integrated model to the treatment of Alex, Brian and Candace. Yet, as detailed below, while this model allowed me to develop strong alliances with each patient, and while it allowed the patients to see their use of illusion to maintain relationships, it did not necessarily allow the patients enough distance from their narcissistic personality disturbance to free them from the familiar constraints of their narcissistic orientation. While Mitchell's model seeks to open up space for the patient to question the function of his narcissistic illusion(s), the model does not guarantee that the patient will fully renounce his narcissistic orientation. Mitchell notes that such illusions are not renounced; rather, they are experienced in a broader context, allowing for richer forms of human interaction. As Benjamin (1993) explains, insight into one's personality style is not the goal of treatment. Rather, it is simply a stage. Once the patient has a sense of his dynamics, he then must learn to apply such insight by doing something different and making better choices.

After a thorough consideration of the leading theories concerning the etiology and treatment of narcissism, and based on hundreds of hours working with and considering the dilemmas faced by the three patients under consideration, I wish to add some thoughts concerning the subjective experience of the narcissistic individual in the hope of generating additional treatment options. All of the patients presented in this paper, despite the difference in the presentation of their narcissism, shared a similar subjective experience. In each case, the

patients' inner world was dominated by a feeling of being *overburdened*. Their narcissistic orientation, regardless of its origin, led the patients to blindly believe that they were capable of controlling all aspects of their humanity. They believed that they should attempt to alter to their satisfaction their relationships, careers, bodies, and so forth. Brian was even in the process of reinventing his handwriting so that it appeared more masculine to others. This orientation of endless possibility, while temporarily invigorating for these patients, ultimately burdened them with the belief that they could attain their ideal self. To these patients, it was shameful to settle for anything less. Not surprisingly, the failure of each patient to successfully alter his or her reality to include an ideal mate, job, or body, for instance, left them wracked with disappointment and ultimately served to enervate them.

Further, the subjective experiences of these patients included feelings of emptiness that I propose are the result in part of a *lack of sufficient regard from others*. Like a plant that was left in the dark for too long, these patients evidenced a need to bask in the light (of another's attention in order to feel vital). Unfortunately, in many cases, the light that was offered to these patients was not sufficient. The depth of this lack of regard may be the reason that it is not possible for a profoundly narcissistic individual to undergo meaningful change in a short-term dynamic treatment (see, e.g., Messer & Warren, 1995; Magnavita, 1997). One of the critical elements of a meaningful treatment, conceptualized by many clinicians as a need for extensive mirroring, may also be thought of as a need to remain in the light furnished by the therapist until the patient (not a time-limited treatment) determines that he has had sufficient regard and, as a result, feels full.

With the foregoing in mind, I considered at length how it would be possible to help these patients ease their subjective burden and lack of regard from others. As to the first point, one might argue that a patient who was in touch with his genuine self would be less driven to strive doggedly for perfection. However, I argue that a patient suffering from a narcissistic personality disturbance, even once he is in touch with significant aspects of his authentic self, may still *lack the ability to know what is enough*. In other words, even if a patient is able, for instance, to articulate his wish for dependency in a romantic relationship and if he is better able to pursue a more fulfilling career path, he may still struggle in such a relationship or career to understand the realistic limits of his more authentic choice. The patient has, after all, developed a world view in which more (adulation, achievement, etc…) is better. A more authentic choice does not necessarily mean that the patient does not continue to view that choice through a familiar narcissistic lens.

The benefit of confronting the patient with the reality of his *overburdened sense of self*, *his lack of sufficient regard from others* and *his inability to know what is enough* in life is that it places on the patient a concrete sense of loss and a clearer path to change. First, each patient detailed herein shared a sense of exhaustion that he or she did not fully understand. Each felt as though he or she was constantly running to keep up with all of their obligations. The patients all acknowledged a sense of loss in that their constant feeling of being overburdened left them joyless. Each could not be present in the moment because he or she had duties that perpetually awaited them (such as pursuing a better body, a better job, or more interesting friends). By presenting the patient with the knowledge that this sense of being overburdened is self-perpetuated, the therapist may give the patient the chance to consider the price of his or her

pursuit of perfection. The patient will surely resist this intervention at first and claim that he or she is simply not happy to accept what other more ordinary people will settle for, yet the patient is at least given a chance to examine why he fears such ordinariness. Also he is given a chance to consider what he may be doing to prevent himself from feeling included and connected to other people who value relationships over perpetual achievement.

Second, despite the defensive counterdependent presentation of each patient, each patient evidenced a deep hunger for connection. Upon investigation, it was apparent that the patients had suffered on this front in two ways. First, each patient had had caregivers who had ignored the patient's genuineness, and each had become a narcissistic extension of his (or her) parents. This fact was not surprising. Yet, second, Alex and Candace in particular had developed a persona that effectively repelled regard from others. Each had emerged in adulthood as the "rock" for all of those around them – parents, romantic partners and friends. As a result, these patients effectively signaled to the individuals in their life that their regard was not wanted/needed. They were left alone in the world as supposed islands who could function without the very basic human need to be considered. They had unknowingly convinced other people that in essence they could be taken for granted. If the clinician is able to help the patient come to see that he has participated in the creation of such disregard by others, the patient may be filled with hope by being reminded of the benefit of relatedness (including the fact that all relationships need not be burdensome). It is well known that narcissistic patients deny a need for connection; however, the strength of their transferences, and their clear invitations to me to enter their worlds on the only terms that each knew, makes it apparent that they longed for something different.

Third, and perhaps most important, each patient presented with a clear inability to answer the following question for him or herself: *what is enough*? Despite each patient's unique pursuits, one of the most striking things about my work with the patients in this study was their inability to know when they had achieved enough to grant themselves permission to stop their pursuit. Without the internal ability to answer this question for themselves, the patients repeatedly deferred to external appraisals. In the absence of internal scaffolding, they had no choice but to look outward to challenges, deadlines, etc., to prompt and inform their actions. If the clinician has the ability to present this difficulty to the patient, the patient will be afforded the chance to reflect, perhaps for the first time ever, about what he regards as *good enough*. The patient at first will surely set the bar very high, for this is his habit. Yet, the door will be opened for the patient to consider the fact that at present he may have no limits in mind. He may harbor the vague yet burdensome view that more is always better.

The Treatment of Candace, Focusing on the Problem of Work

Assessment of the Patient's Problems, Goals and History

Presenting problem.

Candace presented to treatment with depressive symptoms, including anhedonia and recurrent feelings of hopelessness. It was apparent from the outset of treatment that Candace was suffering greatly at work. She had attended an Ivy League college and then gone on to attend the most competitive business school in the country. She regarded her business school years as a "joke;" she commented that an M.B.A. was not a "real" professional degree, like a medical school or law degree, each of which afforded its holder "meaningful knowledge." She found her

graduate studies easy and was not surprised when she landed a high-paying job after graduation with an elite management consulting firm. She discounted her work as “inane” and called herself a “slide monkey” (referring to her principal job function of doing industry research and then distilling the findings into easy-to-understand PowerPoint slides).

Yet, despite the disdain that she held for her job, Candace could not imagine leaving this position. After all, she was at a premier consultancy firm, one that was well known to and well regarded among her peers. She could name several classmates who fought diligently but without success to land the position that she now held. On the one hand, she knew that she held a coveted role. Yet, on the other hand, she knew that her job was causing her anguish and played a significant role in her depressive symptoms. She was paralyzed with indecision. She was certain that her next professional move would be a “disaster” and would lack the luster of her current position. She feared that a position at an ordinary corporation would further depress her. Above all, she feared that her departure would signal that she was “soft” and could not handle the rigors of a male-dominated profession.

Family and developmental history.

Candace was raised in an intact home as the middle of three children; she had a brother three years her senior and a sister three her junior. Her parents had met and married in Japan, and the couple had relocated to North America before having children. Her father was a midlevel executive in a U.S. office of a major Japanese corporation, and her mother was a homemaker who never truly embraced American culture (including the language). Candace

attended public school in a mostly Caucasian suburb during the week, and she attended Japanese language and culture school on Saturdays.

Candace did not appear to be a socially-gifted child; in fact, during the course of treatment, she mentioned only two friends by name and she did so only on a handful of occasions. Instead, Candace's childhood appeared to be filled with obligation. She was not male, so she did not enjoy the cultural privilege that her brother's gender afforded him. Further, according to her, she was not beautiful, so she did not enjoy the attention and praise given to her little sister. Instead, she was the "smart one." She excelled in school and took her duties as a student seriously. Her evening and weekends were filled with studying, and she diligently learned about Japanese language and culture in the event that the family ever needed to be relocated to Japan. She lived under her mother's constant threat that Japanese students were far more advanced than American students and that she would surely be "behind" if they ever returned to Japan. In effect, Candace spent her adolescence preparing to attend Harvard (where she was ultimately not admitted) and/or preparing for a possible move to Japan (which never materialized).

Diagnosis.

Candace was diagnosed with a narcissistic personality disturbance with both entitled and depleted features. In terms of her narcissistic orientation, Candace was struggling with issues of authority, entitlement, self-sufficiency (counterdependency) and superiority. Her concerns about vanity were not readily apparent in session but were confirmed by the NPI.

Strengths.

Candace's strengths included her above-average intelligence, her ambition and willingness to work hard, her evident organizational and leadership skills, and her reliability. Also, in line with her ambition, I would include her deep motivation for treatment as a strength. Candace faithfully attended treatment twice a week for eleven months as she was highly-motivated to "conquer" her recurrent depressive symptoms. Under her grandiose demeanor, she was quite likable; she had an excellent sense of humor and in time evidenced a deep desire for a mutual relationship.

Formulation and Treatment Plan

Formulation.

At the outset of treatment, Candace presented like a narcissistic patient with grandiose features but one whose grandiosity was wanting. As she detailed her numerous credentials and then devalued them, the harshness of her superego took center stage. Any efforts that I made to get her to acknowledge how critical she was of herself or any attempts that I made to have her engage in self-care were met with anger and dismissive remarks. On one occasion, early in treatment, I asked her to fantasize about other types of work outside of her current field that she might find interesting. Candace repeated the word "fantasize" as if it were a vulgar word, and she then launched into a tirade about how she could not imagine anyone wanting to be in the field of psychology. She made it clear that she regarded the field as "soft" and unscientific. It was clear that she was only interested in things that were "hard" because, for her, to be hard meant to be worthwhile.

Despite her grandiose aspirations, her depleted self was always in the room. I considered Candace as both an entitled narcissist and a depleted narcissist because, in part, her narcissistic illusion of grandeur was permeable. For Candace, her grandiosity served the purpose of defending against both shame and depression. Yet, her defense held only for a short time before her depression (in the form of feelings of inadequacy about herself) surfaced. But, further, for Candace, I suspect that her grandiosity served as a thin defense against her aggression. She often alluded to a belief that she was uniquely competent and self-sufficient and that, in contrast, others were weak and unreliable. Candace came to treatment because she found it hard to reconcile the grand, "hard" woman - for instance, a woman who "duped" new recruits into joining her firm with lavish dinners on the town – with the exhausted woman who went home to a dirty house that she was too tired to invest in.

In the session after Candace belittled my career choice, she apologized for her "inappropriate behavior" and assured me that she valued the work that we were doing together. This exchange brought into focus the function of Candace's grandiose illusion as well as its major limitation. Candace used her achievements to draw attention to herself and lure people to her. Yet her intermittently abrasive style was frequently off-putting and ultimately pushed people away from her. So, as discussed below, she also relied on an illusion of sameness to further secure her connection with others.

Treatment goal and plan.

The goal of treatment was to have Candace acknowledge her narcissistic orientation and its function in keeping her safe from disappointment (in herself and others) while still maintaining relations with others. Further, in view of her depressive symptoms, it was crucial to

help her understand the role of her narcissistic illusions in her current work-related distress. Shortly after treatment began, Candace took a leave of absence from her job once she realized that her role was overwhelming her. At that point, the goal of treatment changed to having Candace appreciate and to keep in mind such illusions as she considered leaving her job and then seeking another, more suitable position. I sought to help Candace appreciate that she was prone to make career decisions that were focused exclusively on the appraisal of others to the exclusion of her own genuine interests. The initial plan was the application of Mitchell's model in the hope of allowing Candace and me to play with her narcissistic illusions.

Course of Treatment

Early phase of therapy: alliance building (Sessions 1 to 12).

The building of an alliance with Candace occurred in fits and starts. On the one hand, I was able to quickly deepen the alliance with Candace when she came to session and her depleted narcissistic traits predominated. During those early sessions, she was deflated and able to consider that she could benefit from therapy. Yet, on the other hand, such alliance building could be stalled or even undone when she would then come to a subsequent session and her entitled narcissistic traits were at the forefront. I can recall hoping on certain days that the former Candace would appear in session because my early work with Candace as a depleted narcissist felt more genuine and rewarding. In time, however, Candace began having trouble reconciling her different presentations in session. As addressed above, did she find my profession worthy of scorn or did she value the work we did together? By the twelfth session, she realized that the answer was both. Her dilemma came into sharper focus for her, and she was able to settle into treatment in an effort to understand these incongruous parts of herself.

Middle phase of treatment: application of Mitchell's Integrated Treatment Model (Sessions 13 to 70).

As suggested by Mitchell, I joined in Candace's illusions of grandiosity (which was present regardless of whether she presented as entitled or depleted). The patient was inviting me to admire her and I did so. I marveled at her achievements, the ease at which she had risen to an elite position and, above all, the universe of career possibilities that lie ahead of her. At the same time, however, I expressed curiosity about how she had come to be so deadlocked in her current career choice. I wondered whether she believed that she needed to be so accomplished in order to have captured and maintained my interest? what did it feel like to expect so much of herself while at the same time receiving, in her view, so little from others? did she fear losing her luster if she acknowledge the parts of herself (including certain interests) that were not so grand?

Further, I accepted but did not examine her twinship transference. Before proceeding, I wish to note that I am the oldest member of my cohort, having had 10-year career in corporate securities law before starting my graduate studies in clinical psychology. I disclosed this fact to my first therapy patient in graduate school when this patient asked why I was so much older than the other student clinicians. In hindsight, I felt that this was a mistake as this disclosure was done in order to make myself feel more comfortable at a time when I was highly anxious as a new clinician. Since that time, I have never shared this information with a patient. Unfortunately, with respect to Candace, this information was shared with her by an intake coordinator before we had met. She then went online and had a full sense of my professional history before the first session.

In the transference, Candace maintained an illusion of sameness with me. I suspect that it was this sameness that created in her mind the foundation of our relationship. She could display her achievements boldly, but, in her mind, she was not being intolerable because we were the same. We both had distinguished educational degrees and we both had worked in the hard, male-dominated world of corporate finance. In her mind, we both had given up our lives for work, having worked sixteen-hour days and countless weekends, and, to her mind, we both were no stranger to airports.

I understood the patient's twinship transference to be a defense against feelings of aloneness and the fear of rejection (and perhaps too a defense against a fear of retaliation as she boldly flaunted her achievements to me). This transference masked her belief that if we were not the same then she was fundamentally different and, as such, alone in her struggle. While, at first, in service of building the alliance, I was able to accept her invitation to share our similarities and view this as an opportunity to connect, I also knew that her transference needed to be played with or else it would eventually be an impediment to treatment. In time, I began to explore with playful curiosity Candace's early object relations and how she understood her ability to successfully connect with others. It was not surprising to learn that as a child Candace felt her connection to her father was based primarily on her ability to identify and amplify the similarities between father and daughter (she developed an interest in fishing just so she could spend time with him on the weekends). This task became all the more crucial since Candace felt that she has nothing in common with her mother.

With this information in hand, in time, I began to distance myself from the patient's belief in our samenness. It was important to demonstrate to Candace that her tendency to relate

through a display of achievement as well as through elements of perceived sameness was limiting her ability to explore the numerous and important differences between us.

Candace: I spent the morning at the vet. The dogs needed shots, nail clipping, ear cleaning. You know, the usual. The bill was nearly $200.

Clinician: What?

Candace: Crazy, right. I saw you have a calendar with bulldogs on it. Do you have a bulldog?

Clinician: What do you think?

Candace: We don't have to play this game. I was being coy. I saw you walking your dog in XXX Park over the weekend.

Clinician: Okay then, yes, I do have a bulldog. And now I get a lot of gifts featuring bulldogs.

Candace: Your dog looked small. Is it a puppy?

Clinician: She's about two years old. She's just small for a bulldog. So why the coyness?

Candace: I know that you [therapists] are all weird about your private lives.

Clinician: Why do you think that is?

Candace: So patients do not show up at your house at night. (Laughing). Or stalk you when you are walking your dog on the weekend.

Clinician: Did it feel weird for you to see me out of the office?

Candace: No. (Pause.) A bit invasive.

Clinician: If you were me, you would have wanted to be left alone?

Candace: Hell, yes. I don't want my work crashing in on me on the weekends. Work is for weekdays and weekdays only. Unless, of course, my f**king boss decides otherwise.

Clinician: Would you be surprised to learn that I love my job? That I actually read psychology books on the weekend. (Laughing.) I have even spent a few weekends at conferences.

Candace: You are sad, man. (Laughing.) You need a life.

Clinician: I am pretty comfortable that I have a life.

Candace: I get paid all week to do dull s**t that I could care less about. I am not going to spend a moment of my free time thinking about that stuff.

Clinician: Well, maybe that's one difference. I'd only want to be paid for something I loved to do. Not something that I thought sucked. I guess, that way, the line between the week and the weekend isn't so bright for me.

In time, Candace grew more able to set aside her need to base our relationship on our similarities and she risked exploring our differences. For instance, she acknowledged that she had been harboring the illusion that we were both homebodies who preferred a night in front of the television, in the midst of our messy apartments, to socializing. However, she allowed room in our work together to appreciate that this conclusion was based on fantasy rather than fact. As Candace let go of this twinship transference, her ability to stand apart from and play with her grandiose illusion grew. She came to appreciate that as a child she craved the attention of her father. At the same time, she appreciated that she held disdain for her mother and her life choices. According to Candace, her mother had moved to this country as a new bride in her twenties and spent her life "chronically disappointed" with her marriage, her children and the United States. Along with these realizations, Candace was able to appreciate that, despite her efforts to capture her father's attention, he never really seemed that interested in his daughter. He only seemed to respond to her when she fell short of his expectations.

Further, Candace revealed that she had spent her high school years tirelessly preparing to attend Harvard. When she learned that she had not been admitted, she grew depressed and ultimately attended the elite school that her father deemed the next most acceptable institution. Despite her view that she was "shockingly lazy," Candace graduated from this top university with honors. Her decision to go to business school stemmed from an uncertainty as to what to do

with her life. Despite her ambivalence about her studies, she again graduated with honors. All the while, Candace maintained the illusion that human connection was maintained though the garnering of enviable achievements (giving her worth and drawing people to her) as well as a reliance on finding "[her] people" (giving her a false sense of connection to individuals with similar credentials).

Yet, despite the patient's insight and her new-found ability to look at her narcissistic illusion and its function, Candace was still not free of her tendency to make choices based on their perceived value to others as opposed to her genuine interests. She still could not afford herself space to consider leaving the elite job around which her initial presenting conflict centered. At this time, she was aware of her narcissistic dilemma. For instance, she discussed one day in session her envy of a classmate who had recently been given a position at her business school as an assistant professor. She was able to distance herself from such envy, to identify its narcissistic origins, and to articulate that her envy made little sense since she had no aspiration to being a professor. Yet despite her acknowledgement of the narcissistic lens through which she viewed this situation, she was stuck.

Final phase of treatment: application of adjunct intervention and termination (Sessions 71 to 83).

As noted, Candace eventually revealed to me that she had recurrent passive suicidal ideation. There were times when her life felt so mired in obligation that she did not see the point of living. She had no sense of joy and she lacked the ability to be spontaneous. She felt as though she was expected to go to work, to the best job possible, and that at work she was expected to capitalize on her business degree. When asked why she held these views so

absolutely, she would reply, “because to do anything else would be stupid, a waste.” This view led Candace to feel as though she could see her entire future, and it was a future of “endless drudgery.” She could not help but feel an obligation to be her best even if she regarded her path as bleak. Yet this understanding did not prompt change. I felt that I had a unique avenue to explore with Candace; we were similar in her view, yet, I had made a significant career change. Unfortunately, this subject was never pursued, as Candace expressed no interest in this topic and never opened up an opportunity to explore it in session. Now I felt stuck.

At this juncture, I felt as though I were beyond the wisdom of prevailing theoretical models. I had accepted Candace’s grandiosity and need for twinship and I had explored both needs with curiosity. She was able to articulate her narcissistic world view and to play with it. However, her presenting conflict remained. So I decided to inhabit more deeply Candace’s subjective world, as advocated by Kohut. What did it feel like to be Candace at this stage of the treatment - to see one’s dilemma but not to trust one’s own feelings of discontent? I decided to address her internal state; specifically, I addressed her subjective feeling of being overburdened. In the spirit of Mitchell, I kept engaging her grandiose illusions, as well as her need for twinship, while wondering aloud about the exhausting price of her pursuits.

Clinicians are accustomed to working with dream material. Candace, however, found the exploration of dreams “retarded.” Instead, I found that an exploration of her daydreams provided direct access to her subjective state of being.

Clinician: You found your mind wandering during the meeting?

Candace: I was a million miles away.

Clinician: Where were your thoughts?

Candace: You know how the audience will clap when a contestant on Jeopardy correctly answers all of the questions in the same row? I found myself daydreaming that I not only correctly answered all of the questions in one row, but that I then moved to the next row and then the next row. One row after another, I beat the other contestants to the buzzer and I just knew the answers. I got all of the answers right. The other contestants had to just sit by and watch as I cleared the board.

Clinician: So there was no point in playing final Jeopardy?

Candace: I guess not. Or maybe I played it alone. Maybe I bet it all and I got the answer right. That would be nice. I could use the cash now.

Clinician: In addition to the bonus that you got in January?

Candace: I thought about what you said. About the feeling of drowning in responsibility. If I could choose, I decided that I want to start a bakery company. A cupcake truck, actually. A mobile bakery.

Clinician: But you need to be a Jeopardy champion to have enough of a cushion to go for it?

Candace: If only. I can think about the cupcake truck for a second but then I stop myself. The mortgage, the bills, if I ever have a kid…

Clinician: And your parents' reaction to your new venture?

Candace: I can imagine that phone call. They would probably get in the car immediately and drive down here to see if I was losing my mind.

Clinician: But they don't have to get up each morning and go to a job that they hate.

Candace: I don't hate it. I just...(laughing)…I just dread it.

Clinician: But, in any case, you are left with no room to consider your bakery truck.

Candace: I'd be great at it. I have a name picked out already. XXX. And I have a stack of recipes that I'd use.

Clinician: So it would make you happy but you wouldn't get the prize money at the end of the episode?

Candace: Doubtful.

Clinician: What would you get?

Candace: Fatter, for one thing. But I would get my time back. And a feeling of ownership, I think. And lots of happy customers. I would probably get a good night's sleep for the first time in ages. You know, the kind of sleep you get after an honest day's work.

In time, Candace allowed the notion of being overburdened to settle over her. In session, she pointed out several people in her life who were not high achievers but who seemed happy nonetheless. She concluded that these individuals had found satisfaction in life without competition and external affirmation. This notion intrigued her. Her new knowledge placed a different burden on her: she was now faced for the first time with the task of trying to assess how she was responsible for her own feelings of "drowning" in obligation. With the realization that she was responsible for and had some measure of control over whether she felt dread on a daily basis, Candace embarked on a new project. She set out in treatment to consider how she could improve her mood and abate her passive suicidality by reducing her own sense of being overburdened.

Ultimately, Candace left her job at the elite consulting firm. She did not abandon her job in favor of the cupcake truck. However, in a bold move for her, she joined a new consultancy firm in an administrative department. She labored over this decision and feared that she would regret not being on the "hard" revenue-earning side of the business. Yet, in the end, she was able to understand that this new position would improve her mood by giving her control over her hours and pride in her efforts. Further, and most surprising, this new job would allow Candace to engage directly and on a daily basis in a new activity that she learned was important to her – relationship-building.

The Treatment of Alex, Focusing on the Problem of Intimacy

Assessment of the Patient's Problems, Goals and History

Presenting problem.

Alex had presented to treatment with concerns about his professional future. He had invested a decade in his rock band. While he was able to make a living from the band, they had yet to attain the commercial success that Alex thought that they deserved. Despite this presenting issue, Alex quickly set this matter aside and focused instead on his romantic life.

Alex was used to always having a girlfriend. Yet none of the women that he dated of late were on par with Jenny, his first girlfriend from nearly a decade earlier. When Alex was 20 years old, he met Jenny, a girl from a wealthy Connecticut family, then a junior at an Ivy League school. Alex had never met anyone like Jenny before; after all, he was the child of an electrician and a homemaker, and he had attended a state university. Although the couple dated for only nine months, and although Jenny appeared to have handled the breakup of the relationship in a childish manner, there was a large part of Alex that lost his ability to love when Jenny left his life. None of the women that Alex met after Jenny had her "sparkle."

In recent years, Alex had dated two women – Alyssa and Katie. Both women, as described, were pretty, "smart enough", and, to Alex's delight, not really interested in the whole "marriage and kids thing." In both cases, the women were "devoted" to Alex, and, yet, I suspect that neither of the women had the confidence during the relationship to assert her real interests or to complain about any perceived shortcomings in the relationship. To Alex, these women were ideal – they were available when he wanted their company and they did not complain when he was not in the mood to be part of a couple. Alex was convinced that these women shared his

desire for a “relaxed” relationship. In both cases, however, the women eventually reached a breaking point and, without much discussion, ended the relationship with Alex. Alex was dumbfounded. In each case, he had been confident that the relationship was going well and that his partner was content. He combed through the final interactions with each woman in search of the clue that would help him understand why each relationship had ended. It was painful for Alex to accept that there were shortcomings in the relationship because he felt that few men could offer these women more; he was handsome, talented, kind, smart and might possibly be a rock star some day.

Family and developmental history.

Alex was raised in an intact home as the youngest of three children. At the time of his birth, his parents were in their late forties, and his brother and sister were already teenagers. His parents, strict Catholics, never told Alex that he was the result of an unplanned pregnancy. However, Alex reported that their advanced age and clear lack of interest in parenting left him with the feeling that he was not “part of the plan.” Alex recalled that he spent a great deal of time and efforts trying to connect with his father and two siblings through his willingness to join in their respective interests.

Unfortunately, Alex’s older brother had a serious drinking problem, which occupied a great deal of his parents’ time and attention. Alex reported that when he was 12 years old, his brother, then 24 years old, had a serious non-fatal car accident while driving drunk. According to Alex, it was at that moment that he lost his parents. From the date of the accident forward, Alex’s parents focused all of their energy on their oldest son. Alex learned at a young age that he could receive positive regard from his parents if he was a good boy, one who made few

demands. He did well in school, attended church with his parents and quietly played his guitar in his bedroom. Alex accepted that he would never be the center of his parents' world. At least, he concluded, he could not add to the evident distress that his older brother caused them.

Diagnosis.

Alex was diagnosed with a narcissistic personality disturbance with entitled features. In terms of his narcissistic orientation, Alex was struggling with issues of exhibitionism, entitlement, self-sufficiency (counterdependency), vanity and superiority.

Strengths.

Alex's strengths included his above-average intelligence and his creative mind. While Alex may have suffered from myopia (i.e., a lack of life experience and knowledge of possible ways to live), he did not suffer from cognitive rigidity. If his shame was not activated, he was able to play in session with concepts and to use his creativity to conceptualize the material under discussion in new and promising ways. Alex was also very honest; if material was too difficult to tolerate, he avoided it entirely as opposed to revising it in his mind in order to make himself temporarily more comfortable. Alex had a well-developed sense of morality.

Formulation and Treatment Plan

Formulation.

Alex presented in session as an earnest young man in search of a wise mentor to help him make sense of his life. He was a bright man with an analytic mind. He appeared able to consider his life and choices. In therapy, he sought confirmation from an expert that in a variety of situations he had indeed acted properly. The problem, however, was that Alex formulated his

analyses on certain false premises and therefore often arrived at conclusions that were lacking a basis in reality. He appeared to base his views on an unconscious system of hierarchies; for Alex, everything – including people, jobs, rock bands, restaurants – had been unconsciously assigned a value (and, therefore, a worth). For instance, Jenny had been assigned a greater value than Alyssa or Katie. In making his decisions in life, Alex assumed that he was entitled to the partner, job, etc. with the highest value.

In treatment, Alex evidenced an idealizing transference. Alex was "skilled and seductive in the art of discipleship." (Mitchell, 1988, p. 226). He was a generous patient, reminding me frequently that he valued greatly the time that I afforded him. He often repeated the words that I spoke and, at times, wrote them down in a notebook so that he could review them later. Interestingly, despite his assertions that he valued my time, early in treatment, Alex often cancelled sessions, changed appointment times, and requested phone sessions. At times, it felt as though he was seeking an omnipresent therapist who was available on an as-needed basis.

Treatment goal and plan.

The goal of treatment was to have Alex acknowledge his narcissistic orientation and its function in keeping him connected to others while allowing him to not share with others any of his vulnerability. In view of his discontent with his romantic and work lives, it was advisable to help Alex to understand the role of his narcissistic illusion in keeping him isolated. At this time, he focused more on all of the possibilities that lie before him as opposed to committing to a certain person or job and building on that commitment. The initial plan was the application of Mitchell's model in the hope of allowing us to play with his narcissistic illusions.

Course of Treatment

Early phase of therapy: alliance building (Sessions 1 to 5).

The building of an alliance with Alex occurred very quickly. This may seem unusual for an entitled narcissist; however, Alex was used to maintaining connections with select others through idealization. From the outset of treatment, I could say or do nothing wrong. Alex absorbed every word that I said, and he cast himself in the role of eager student.

Middle phase of treatment: application of Mitchell's Integrated Treatment Model (Sessions 6 to 52).

As suggested by Mitchell, I accepted Alex's invitation to be the ideal therapist. It was fun at times to play with the illusion that I may indeed be extraordinary. Yet, at the same time, I challenged Alex's illusion. I would wonder aloud why was it important for him to assume that I was "the best" at my job? why did he assume that I was better than the therapists seen by his friends? and, most importantly, what would it mean to him if I was just another well-intentioned but ordinary therapist?

In addition to his inability to properly read the women that he was dating, Alex had a difficult time accurately reading his family members. He reported on numerous occasions that his various family members were looking forward to his visits; however, once he arrived, he would find them unavailable (either not home or involved with other more pressing activities). Further, as noted, Alex had learned from an early age that he would be well-regarded by his parents if he was a "good boy" who was seen and not heard. This role followed him through college where he studied hard, engaged in community service, dated but never had sex and refrained from drugs and alcohol. In view of Alex's inability to accurately examine the primary

relationships in his life or to take up any real space in such relationships, I suspected that Alex's idealization of me was defending against a fear of aloneness. If I was not fully attuned and perpetually available to Alex, I suspected that he feared that he would be confronted with how alone he felt in the world with his struggles. His idealization of me allowed him to cast aside reality and feel as though he was someone who deserved the special position he held relative to me.

Alex's deep desire for perfect synchrony with me in session, while flattering, also had a deadening effect on the treatment. He yearned for an *us vs. them* stance in session, and he left little room for disagreement between us. His compliance was stunning. My attempts to discuss with Alex the limitations of his deference were unsuccessful. Eventually, I decided that I needed to risk a rupture because, among other things, it was important for Alex to acknowledge his illusion and to try to relate to me in a manner more grounded in reality.

Alex: I've been kicking the tires on some different options. Social work school sounds like a pretty good option. I like that I can get out quickly and help people, and I don't have to be in school forever. How long will it take you before you graduate?

Clinician: It should take about six years in total.

Alex: There's no way…if I went to social work school, I'd be done and ready to see patients in two years. And, best of all, I could go to [Ivy League university]. I was checking out their catalogue online over the weekend. I could take most of my courses at the social work school but I could also do electives in some of the other departments. At the School of Public Policy, for one.

Clinician: And then you'd hold a degree from the same school as Jenny.

Alex: That's right. I would. That'd be cool. I liked [state university]; I learned a lot there. But I have to say that I always thought that I was better-suited to a school like [Ivy League university].

Clinician: Because?

Alex: I had a 3.9 in college. I needed a greater challenge. Also I like the idea of [Ivy League university]. It's like an exclusive army. I bet that if I went there, there'd be a network of people willing to help me out once I graduated.

Clinician: You have never mentioned an interest in social work before. Have you made a decision about the band?

Alex: I like the idea of helping people. Like you do. (Silence.) No, I haven't made any decisions yet. But, I do think that I'd like to help people. Professionally.

Clinician: Wow. This one plan will allow you to have an Ivy League degree just like Jenny and a job just like me.

Alex: I guess so.

Clinician: You look upset. Did I offend you?

Alex: Kind of. A bit.

Clinician: Tell me how.

Alex: Well, I had this idea. An idea that I was excited about. I feel like I've been scolded.

Clinician: I just want us to look at your thought process more closely. (Silence.) You are struggling with whether or not to stick with music – your passion – and, in the middle of this struggle, you come up with a solution that combines parts of two people very important to you. Is it fair for me to say that I am important to you?

Alex: More important to me than Jenny, for sure.

Clinician: Because I feel like Jenny, a person who you have not seen for over a decade, still holds a lofty place in your mind. (Silence.) I don't want you to feel scolded. I want you to look at this plan – a plan very different from anything we've ever discussed in here before – that moves you closer in a way to both Jenny and me.

Alex: Are you saying that I am unoriginal?

Clinician: I am wondering if it is your way to strengthen your connection to people you hold in high regard.

Alex: You asked me to play with some career ideas. And I did. I like the idea of helping people.

Clinician: More than music?

Alex: No. But it seems to make you happy. And it would be a steady paycheck.

On that day, I moved away from further discussion of Alex's plan for fear of further shaming him. However, a seed had been planted. In time, Alex's ability to play with his need to idealize grew. He made a particularly large step forward in his ability to play with this illusion when he decided to affirm his true interests and remain in his band despite its lack of commercial success. He could tolerate being associated with the band even if it was not ideal (i.e., commercially successful). In making this choice, he renounced his plan to become a therapist. This decision opened the door to a discussion about the comfort that he felt by putting others on a pedestal and co-opting their interests. He was able to appreciate on an intellectual level that it allowed him to be connected to others without having to reveal himself and without having to make any mistakes of his own. In time, he was also able to consider that as a child he would have been entirely alone had he not honored his father and siblings with an allegiance to their interests. Alex now had an intellectual but not affective understanding of his dilemma.

Final phase of treatment: application of adjunct intervention and termination (Sessions 53 to 68).

At this juncture, I felt as though I were beyond the guidance of prevailing theoretical models. I had accepted Alex's idealization of me, and I had explored it with curiosity. He was now able to see that he was prone to idealize others in an effort to maintain relations. He was likewise able to see the other side of the coin; he now understood that he was prone to devalue those individuals whom he did not deem worthy. Regardless, his presenting issue had yet to be resolved. At this point in the treatment, he had met another woman, Zoe, and he had fallen into a familiar pattern with her. She was "the best", "so chill", and "not pushing for anything more."

However, I suspected that once again Alex had become involved with a woman who was not clearly expressing her full interests, and he was capitalizing on this fact for his own comfort. This arrangement kept Alex safe. He was not alone (he was part of a couple); yet, he was not pushed to reveal himself (hence, he did not risk any shame).

Despite Alex's newfound knowledge, he remained in danger of a similar outcome. I decided to focus more deeply at this time on Alex's subjective world. What did it feel like to be Alex at this point in treatment – to want to connect with people so badly that he could still, with growing awareness, choose to discount the entirety (reality) of the other person? to desperately want to be intimate with another but to be terrified of exposure? I decided to address his internal state directly; in particular, I addressed his lack of sufficient regard from others. Guided by Mitchell, I continued to join his illusion while introducing to Alex that fact that his strategy for avoiding aloneness was in fact leaving him more alone than ever.

As expected, it was difficult to introduce to Alex the notions that he was hungry for connection and that he may suffer from a chronic disregard from others. Yet, as treatment progressed, Alex grew more willing to consider the limitations of his parents and to sit with the idea that, given the make-up of his family, he had been a very lonely boy. When I asked him whether he felt that his tendency to idealize others added to his current loneliness, he balked. While he used other language, he was certain that some degree of allegiance was required in all relationships. Without some degree of worship, what then could bind two people together? I offered several options: love, mutual interest, need for affection, fear of loneliness… He disagreed and felt that for a relationship to survive something more was required.

Alex was reluctant to believe at first that he could maintain a relationship with another without having something tangible to offer the other person. He had offered his parents his obedience, and he had offered his siblings his unwaivering devotion to their interests. As for Alyssa and Katie, his two former girlfriends who departed without explanation, I suspect that he had offered them an ideal man (until, of course, this handsome, intelligent, creative man used them one too many times as a selfobject). Yet, one day, Alex was willing to consider my question. Was it possible that he was valued for who he was and not what he did for the other person?

Alex: Is it weird for you when you end with patients? When therapy is over?

Clinician: Weird?

Alex: I don't know. Sad, I guess. You're left to wonder what happens to them. Unless they come back to you.

Clinician: It is sad. For me. Are you wondering what my reaction will be to the end of our work together?

Alex: It's hard to know, when you're the patient, if you're just another file folder. We have these images from television of doctors running around all day, trying to keep ahead of all of the work that they have.

Clinician: But this is quite different. You might spend a couple of minutes with your medical doctor, but you and me…we have spent a considerable amount of time together. (Silence.) But, to answer your question, I will be impacted by the end of our work together. I think highly of you. Of the effort that you've put into therapy. Of the risks you have begun to take.

Alex: I don't want you to think I was fishing for a grade, or something.

Clinician: I don't. Not at all. It's perfectly normal to wonder about your impact on me.

Alex: Well, you've helped a lot. A lot a lot. Maybe I will check in with you sometime if that's OK. I guess I would need your email for that.

Clinician: I'd be happy to give it to you.

Alex: But we have time, a few more weeks.

Clinician: We do. But it's important to talk about this stuff, I think. To use this time to consider our time together. Our relationship.

Alex: Well, other than a few times when you made me mad, I think we worked very well together. I think we speak the same language. I'd thought that maybe I'd get you a present. A thank you present. Some CDs, maybe. (Silence.) But then I was afraid that might not be the done thing.

Clinician: You have given me enough already.

Alex: No.

Clinician: You've trusted me with your struggles. You've taken risks. You've worked hard, [Alex]. And that is enough.

Alex: That sounds like nothing. But I will trust you on that.

While Alex may have expressed skepticism on that day, he was able to end treatment without a need to give me something tangible. He appeared able to open up and consider that our relationship was sustained by him being genuine and not by him being useful.

At the end of treatment, Alex was still dating Zoe. After some encouragement, Alex agreed to have a conversation with Zoe about her wishes for the relationship. According to Alex, Zoe had affirmed her disinterest in having children. She had, however, expressed the wish to build a home with a husband. This admission scared Alex; he was concerned in part that, as a musician, he would never be able to afford a home. Yet, as opposed to ignoring this fact, he was able to discuss with Zoe his concern that he may not be able to offer her everything that she desired. He was genuinely surprised to learn that Zoe accepted this and was nonetheless interested in maintaining the relationship. While Alex harbored a concern that she may be after something from him not yet articulated, he tolerated his fear and remained in his relationship with Zoe. Perhaps the other shoe would never drop.

Alex told me during our last session that he loved Zoe and that there was something about her that made him want to stay in the relationship. “It’s the way she looks at me. Even when we are doing nothing particularly romantic or interesting.” Alex had acknowledged a chronic lack of regard from others. He had also acknowledged that he may be perpetuating such disregard through his need to idealize and the fear of exposing his vulnerability. And, now, as a result of his efforts, he was willing to engage Zoe on more authentic terms and to allow himself to enjoy the regard that she seemed happy to afford him.

The Treatment of Brian, Focusing on the Problem of Play

Assessment of the Patient’s Problems, Goals and History

Presenting problem.

Brian initially presented to treatment with complaints concerning his disappointment about college life. He was not having the “college experience” that he had envisioned for himself. His friends were not cool, his classes were dull, and he lacked the money that he needed to keep up with the students with wealthy parents. Yet, Brian quickly put these matters to the side and focused during our early sessions on the topic of sex. In doing so, Brian never expressed any conflict around his sexual orientation, and he demonstrated no inhibition in session when discussing in the details of his sex life.

To Brian, sex was serious business. Like many gay men of his age, Brian looked for sex online and was well-versed in the rules of “Internet hookups.” He understood that, in order “to play,” he was expected to present online photographs that clearly showed that he was handsome, comfortable with his body, and, above all, desirable. Brian explained that, to be desirable, one

had to be free of inhibitions and never to appear to be “too concerned.” He explained that no one was interested in having sex with someone who was fat, anxious or desperate. The goal of the game was to find the sexiest man that he could, to engage in causal sexual relations, and to be so good at sex that it left his partner craving more. The problem, however, was that Brian, while thin, was neither classically handsome nor comfortable with his body. Further, Brian, a man flooded with anxiety on a daily basis, was not inherently “cool.” A further complication was the fact that Brian often dreamed of romance; his idea of a nice night with a partner was cuddling on the sofa in front of television, not anonymous sex. Even so, it was of great importance to Brian to be part of this online club. For Brian, inclusion was crucial.

Brain presented as if a young child, lost and confused, who pulled for concrete guidance and rescue from the confusion of daily living. Whether it was a matter of organizing his weekly college assignments or interacting with the men in his dormitory, Brian repeatedly came across as if he had been denied access to the most fundamental information about human functioning and interaction. It was very hard for me to resist simply organizing Brian’s schedule, feeding him a few lines to help him start conversations with his peers, and so on. After all, it felt to me that with such information Brian would be far better prepared to successfully engage college life. In time, however, it became apparent that Brian approached all of his relationships in a similar manner and used his wish for guidance as a means to connect with others.

Family and developmental history.

Brian was raised in an intact but staid home as the youngest of two children; his sister was three years his senior. Brian’s father worked as an insurance salesman, and his mother

worked as a retail clerk. Brian never saw his parents display affection toward one another; instead, their marriage had a functional quality to it. Brian's father paid the bills and was otherwise exempted from any obligation to the family. Brian's mother, a highly anxious woman, was responsible for tending to the home and raising the children. Brian's mother was overly involved in her son's business, including his friendships, his wardrobe, and his finances. Her anxiety led her to advise her son to take the safest route in life – befriend the popular kids, wear the latest fashion, save your money for a rainy day. In turn, these lessons left Brian anxious. He was not able to befriend the popular kids, he did not have the "looks" to pull off some of the latest trends, and he never felt as though he had enough money to be the person that he aspired to be.

In the middle of treatment, Brian learned that his father had been having an affair for several years and that he intended to divorce his wife in order to marry his mistress. Brian was conflicted. On the one hand, he was sad for his mother. What would become of her? On the other hand, he was thrilled for his father. His father had suddenly become a fully-rendered character in his son's eyes, one with a sexual side and a desire for happiness. Brian was alone in his support for his father. Brian's sister and extended family vilified Brian's father, and they demanded that he come to his senses and return home to his wife.

The notion that his father had made this momentous decision, and thereby broken the monotony of life at home as Brian had long known it, left Brian confused. Would he become the kind of man who followed his passion? Or would he become the kind of man who avoided stares and whispers by doing what was expected?

Diagnosis.

Brian was diagnosed with a narcissistic personality disturbance with depleted features. In terms of his narcissistic orientation, Brian was struggling with issues of entitlement, vanity and superiority. Unlike many narcissistic patients, Brian did not appear to be counterdependent.

Strengths.

Brian's strengths included his ability to express his vulnerability, his empathy for others, his eagerness to learn, his optimism, and his warmth. Although Brian fed off of the glow of others, he never consciously manipulated other people. Rather, he was a highly social man; and, he genuinely found other people interesting (and, as discussed below) useful. He was well-mannered and always sought to treat others with respect.

Formulation and Treatment Plan

Formulation.

Brian's narcissistic disturbance was not readily apparent, as he did not overtly embrace his grandiosity. Rather, he appeared to be a shy, somewhat depleted young man who was beaten down by the activities of daily living. Yet, in time, it became apparent that under his docile exterior, Brian was in fact a man with strong opinions about his own abilities and entitlements, as well as a clear sense of what was cool and not cool, worthwhile and not worthwhile, and so on. Brian's self-esteem was maintained by a hidden sense of grandiosity; however, this grandiose illusion was buried under a veil of depressive affect. He had a highly diffuse sense of self and was readily able to be whoever others needed him to be in order to capture and maintain their attention (Masterson, 1988). Further, he did not idealize others as overtly as Alex, but he rather

sustained his self-esteem by basking in whatever glow was on offer. He gained access to this glow by never developing his own sense of self. To this end, in session, Brian appeared to be an excellent patient; he was committed to therapy, and, he appeared to be reflecting during the week on the material covered in session. Yet, in time, it became apparent that Brian was coming to session mainly to collect positive regard from me in order to maintain his shaky self-esteem. In session, I was often working harder than Brian.

While at first glance it appeared that Brian was engaging in idealization in the hope of basking in the glow of a more competent other, Brian in fact developed in session a mirroring transference. Brian's developmental arrest was apparent, and he dutifully came to session each week in order to receive the parenting that he had failed to get from his absent father and anxious mother. While Brian was not able to articulate for over eight months any negative emotion toward his parents, he seemed to appreciate that his mother's shallow parenting style lacked the depth and nuance to prepare her son for modern living. Brian had great aspirations for his life, but he was faced in college with numerous small obstacles that he appeared ill-equipped to navigate.

Treatment goal and plan.

The goal of treatment was to have Brian acknowledge his narcissistic orientation and its role in keeping him from developing a more stable sense of self in order to maintain interpersonal relations. Brian believed that the only way that he was able to maintain relations to others was to adopt their interests and, at the same time, to engage in relations only with those individuals that he deemed worthy. The initial plan was the application of Mitchell's model in the hope of allowing us to play with his narcissistic illusions.

Course of Treatment

Early phase of therapy: alliance building (Sessions 1 to 8).

The building of an alliance with Brian occurred very rapidly. Brian was a young man in search of someone to help him regulate his self-esteem. He quickly (albeit unconsciously) concluded that if he presented as an ideal patient, he could come to session each week and temporarily restore his shaky self-esteem. To Brian, an ideal patient was one who came to session regularly and who appeared to use in his life any insight that he gained from treatment.

Middle phase of treatment: application of Mitchell's Integrated Treatment Model (Sessions 9 to 75).

I accepted Brian's invitation to mirror him; in effect, I played the role of the parent who reflected back his sense of growing capability. I allowed Brian to show off his areas of competence; for instance, Brian frequently liked to educate me (in a very polite manner) about why he thought that I was an awful dresser. Yet, once the relationship was well-grounded, I began to explore with curiosity the meaning of Brian's need. This was a delicate matter as Brian was quite prone to shame, and a challenge to his grandiose illusion could again stall his growth.

A recurrent theme in my work with Brian was his desire for more. He wanted more friends, more sex, more clothing, more of my time. I suspected that, for Brian, having more was equated with being cared for and was therefore crucial to keeping his depressive feelings at bay. About four months into treatment, Brian met a young man while out with friends. This man, Scott, was a few years older than Brian and worked as a retail manager of a national clothing chain. Scott made his interest in Brian clear and, soon after meeting, Scott asked Brian out on a date. Brian reported that he was flattered by the attention and that, while Scott was "handsome

enough," he failed to excite Brian because Brian feared that his friends would not be able to see them as a couple (since Brian was, in his opinion, in a "higher league"). Further, and equally troublesome, Brian could not imagine dating a man who worked full-time in retail. Brian felt as though Scott must be flawed; Brain considered that perhaps Scott lacked ambition or was not particularly intelligent. Brian dreamt of dating a man who had more of everything (more intelligence, better looks, more money). Despite his concerns, and with my intentionally overt approval, Brian agreed to go on a date with Scott. Brian reported that, despite his concerns, he did enjoy the date and he was very taken with how enamored Scott was of him. Brian agreed to a second date, a third date, etc.

In time, after the men had been dating for several months, and after the couple had fallen into the habit of spending most weekends together, Brain presented in session with a dilemma. He was falling in love with Scott and he wished to be with him. However, Brian announced that he was not sexually satisfied by Scott. Brian, after all, had always imagined that he would couple with an athlete or some other man with a "perfect body." He noted that scores of desirable men were on offer on the Internet. Brian said that he was in a quandary because, although he loved Scott and wished to be with him, he was certain that he would have to cheat on Scott, and he knew that Scott would be devastated by his infidelity. This dilemma seemed an ideal time to present to Brian the limits of his favored method of relating. Brian was used to having whatever he wanted in the moment so long as there was someone on hand to lend him their glow; in effect, he could have anything if he simply sacrificed a stable sense of self. Yet, now, Brian had to choose. Would he opt for the flawed certainty of Scott or the promise of the illusive glow of online hook-ups?

Brian's ability to stand apart from his need for constant mirroring took a large step forward seven months into treatment when he came to session in a particularly playful mood. Prior to this session, Brian had expressed very little interest in me as a person (Masterson, 1988). On this particular day, Brian was very inquisitive, and he ultimately articulated for himself his central dilemma.

Brian: I was talking to Molly about you the other day. I talk about you sometimes. It's funny. I think sometimes about what you'd say or do. Anyway, she asked me what you looked like. And if you were single. I told her that you don't wear a ring. Am I allowed to ask you if you are married?

Clinician: Do you want to know or does Molly want to know?

Brian: I'm curious.

Clinician: What do you think? Do you have a sense of me outside this room?

Brian: I thought once that you cannot be married because your wife would never let you out of the house in some of those clothes. (Laughing.) I'm only kidding. Let's see. Sometimes I think you have a slight accent, and use funny expressions, so I've wondered if you were born overseas. Like in England. (Silence.) I can imagine that you are married. And have two kids. Twins. Two boys. No, a boy and a girl. Alistair and Abigail. Or something British-y like that.

Clinician: Am I good parent?

Brian: You love them. A lot, I think. But they are too young for us to know yet, for sure. Whether they will end up in therapy for life. Alastair will be okay. He has you to watch out for him. To teach him what to do. Abigail, I don't know. Someone else is going to have to teach her about clothing. And cooking, I guess. You don't seem like the kind of guy who knows how to cook. She might have to pretend to care about Freud if she wants to hang with you.

Clinician: Is pretending her only option?

Brian: You know what I mean. (Silence.)

Clinician: Is it possible that we may have a good relationship even if we have our own likes?

Brian: Of course, it is.

Clinician: But it would be easier for one of us to pretend for the benefit of the other?

Brian: I know where you're going with this. No, it is not better to pretend. But what do I do if I don't know what I like? Or what's important to me? It's easier, safer, to want it all.

Brain now stood apart from his narcissistic illusion, and he was able to see with greater clarity his dilemma. Yet, this insight was not sufficient to allow him to make different choices. He needed something more. Brian had presented an important and therapeutically challenging question – what does the patient (and therapist) do when the patient reports that he is unable to access his own genuine self? Many would argue that insight would allow him to thaw his false self. Yet, for Brain, this did not appear to be enough.

Final phase of treatment: application of adjunct intervention and termination (Sessions 76 to 92).

Again, I felt as though I had reached a point in the treatment where I was beyond the bounds of prevailing theoretical models. I had accepted Brian's invitation to mirror him, and I had likewise explored this invitation with curiosity. He was able to reference his narcissistic world view and to acknowledge how he suppressed his growing sense of self to preserve relations with others. At the same time, his ability to effectively manage the tasks in his own life was growing. However, his initial dilemma remained unchanged. He was still prone to feel that the most effective way to relate was to be a chameleon and to feed off the glow of others. Yet, Brian had fallen in love with a man whose glow was not strong enough to keep Brian's self-esteem buoyant. At this point, I decided to inhabit more deeply Brian's subjective world. What did it feel like to be Brian at this juncture of the treatment – to knowingly rely on the positive regard of another to bolster his self-esteem? to stand at a distance from his own possible interests and opinions in order to guarantee a connection with others? to risk forsaking love because he

was prone to be chronically disappointed in others no matter how much positive regard he collected? I decided to address his internal state; specifically, his inability to answer the question of what is enough? In the spirit of Mitchell, I kept joining his invitation to admire him while wondering with him the downside of being unable to answer this question.

One might imagine that a frank discussion of a narcissistic patient's sexual fantasy life would be too dangerous an undertaking, as it could lead to humiliation (for a discussion of the role of narcissism and sexual fantasy, see Benjamin, 1993, p. 160). However, Brian readily shared with me a recurrent sexual fantasy that furnished insight into his problem with Scott.

Brian: I am sitting on bench in a locker room. It feels like high school. And all of these men are standing in groups. One group is the soccer players. One group is the football players. The other group is the basketball players. They all stand quietly and at attention. (Laughing.) And, I should mention, they are all naked. They are waiting for me to speak. I first dismiss the football players. I have never been attracted to bulky men. They are bummed, but leave. I then dismiss the basketball players. I am not attracted to tall, skinny men. Or black guys. There is some grumbling as they leave. Like they just lost an important game. So I am left with the soccer players. They are now in a line. One by one, they come forward so I can check them out. I decide after a moment if they go into one pile or another, until I am left only with a small group of men who are perfect. Perfect for me. (Silence.)

Clinician: And then you have sex with these men?

Brian: No. [The fantasy] doesn't really go that far. I can't even really see what these men look like. It is more of a feeling.

Clinician: A feeling?

Brian: I don't know.

Clinician: Of control?

Brian: A feeling of not having to decide.

Clinician: The fantasy would be ruined if you had to decide.

Brian: I guess.

Clinician: Well, if you stop there, you never have to find out that they are dumb or insensitive or bad at sex.

Brian: Everyone is bad at sex.

Clinician: Except you.

Brian: Except me.

Clinician: So you are left with a lot of possibility but nothing of your own.

This fantasy underscores the problem with which Brian was wrestling. He was close enough to Scott to now see his flaws, yet, at the same time, his ideal soccer player was beyond his reach. In order to remain perfect, the soccer player would need to remain forever distant. So, looked at from a different angle, it was time for Brian to learn the difference between reality and fantasy and how to negotiate the disappointment of the limits of fantasy.

For Brian, his inability to answer the question of what was enough for him – enough prestige, enough admiration, enough love – had led him to the familiar assumption that more was better. Yet, once he reflected on this question and articulated that his aspirations were unrealistic, it was as if he accepted the imperfection of parental mirroring and the effective use of illusion. In time, others will inevitably fail us and such failures need not be devastating. Likewise, the use of illusion can be invigorating if its limitations are acknowledged and respected. With regard to the question of his love for Scott, and his sexual desires, Brian was able in time to consider that Scott's devotion to him was significant and may indeed be enough for him. After all, he mused, what else could Scott give him? This realization freed Brian to look at his dilemma. Scott loved him. He loved Scott. He had fantasies of perfect sex with perfect men. Yet, these thoughts were merely thoughts, and he learned that they were fueled in part by his amorphous and unrealistic wish for more.

It is also interesting to note that Brian revealed during this time that he feared that a monogamous relationship would brand him as ordinary. Like many narcissistic patients, Brian feared the idea of being ordinary because he feared that this predictable course would result in his losing his "edge" or feelings of chronic boredom. Brian's consideration of what was enough for him in life seemed to free him from these fears as well. He realized that he was playing with an illusion and that, in fact, he need only be exciting in the eyes of Scott.

Brian's ability to play became apparent when he began to joke in session about how seriously he had once taken the game of Internet hookups. The spell of the Internet had been broken and Brian was able to realize that his illusion had led him to be invested fully in something unattainable. He now wondered if it might be possible for Scott and him to have a more fulfilling sex life by adding a sense of play to their intimacy. Brian evidently had a fetish for soccer players, and he played with the idea in session of asking Scott to indulge this fantasy in the bedroom through dress-up.

Approximately nine months after the termination of Brian's treatment, a termination that was prompted by my departure for internship, I received an unsolicited note from Brian. The note was kind, expressive and quite encouraging. Brian reported that he missed me and that he knew that in the past he would have not been able to be so frank about his feelings. He reported that he was doing well at work and that he remained in his relationship with Scott. He reported that he hoped I was doing well and that I was continuing with my studies as, in his opinion, I was a good therapist who helped to improve his life. He wrote that he still struggled with identifying his own interests but overall he was happy and grateful for the work that we did together.

Therapy Monitoring and Use of Feedback Information

The treatment of each patient progressed as expected. In each case, the patients presented for session regularly as agreed (with expected absences for holiday and some early cancellations by Alex) and remained for a course of treatment sufficient in length to apply the treatment principles articulated by Mitchell. In each case, the treatment ended as the result of my departure for internship. At termination, I feel that Alex and Brian would have continued treatment and that Candace was ready to end treatment of her own accord. None of the patients expressed interest in a referral for a new therapist.

As noted, each therapy was supervised by a psychodynamically-oriented licensed clinical psychologist with an average of eleven years of post-doctoral experience. Each supervisor had experience with the treatment of individuals with narcissistic personality disturbances and each was familiar with the work of Kohut, Kernberg and Mitchell. Each supervisor was of the viewpoint that the successful treatment of patients with a narcissistic personality disturbance required a combination of empathic immersion coupled with the eventual exploration of the patient's narcissistic defenses.

For each therapy session, I made use of the feedback received from the supervisor in our previous meeting. Such feedback was informed by a discussion of the content of the previous session, including the patient's emerging needs, as well as the applicability at the time of Mitchell's integrated treatment model and the adjunct interventions as presented herein.

Concluding Evaluation and the Therapy's Process and Outcome

This project set out to (a) assess the extent to which Mitchell's integrated model yields benefits beyond the individual models proposed, respectively, by Kohut and Kernberg; (b) identify those factors in Mitchell's model that appear most efficacious, and (c) appraise the utility of this author's contributions as an adjunct to Mitchell's integrated treatment model. First, the most notable benefit of Mitchell's model is that it does not assume that the function of a narcissistic illusion is the same for all patients. For some patients, it is a defensive avoidance of reality. For others, it is a cry for development. Mitchell's model accounts for and deals with both functions (which may or may not co-occur in the same patient).

Second, Mitchell's model guides the clinician through the treatment of a patient with a narcissistic personality disturbance while allowing the clinician maximum freedom to meet the patient where he is at. It is clearly impossible to predict how long it will take to develop an alliance with a given patient, when the patient will be able to tolerate exploration of his defenses and when he may regress. Mitchell does not allow the therapist to dictate the course of treatment but, rather, he joins the patient on his journey of stepping back from his narcissistic illusion and learning to understand its function.

Finally, and perhaps most significant to treatment adherence, this model furnishes at every step the overarching thing that the patient is seeking – connection. Critics of Kernberg assert that his model fails to account for the fact that you cannot treat a patient who does not come to session (i.e., a patient who has been shamed and who retreats deeper into his illusion by stopping treatment). On the other hand, critics of Kohut assert that his model fails to account for

the real burden being placed on the therapist as he or she waits for inevitable empathic failures and the ability to have a mutual relationship with the patient. Mitchell's integrated model allows the therapist to assess in the moment the patient's ability to tolerate exploration, and such exploration always maintains a playful tone. This tone is often the factor that prevents the patient from being overwhelmed when being asked to consider potentially shameful material and from entering into a competition with the therapist. This tone allows the patient to know that the inquiry is coming from a place of caring and mutual exploration and to keep the patient engaged (for a discussion of the impact of therapist style on treatment dropout rates, see Messer & Abbass, 2010). Also, Mitchell's model allows the clinician to join the patient in his exploration and to not stand on the side lines waiting for the patient to be able to view him as more than just a source of positive regard. It allows, in effect, for a more active, and more rewarding, mutual experience from the outset.

The factor in Mitchell's theory that was most efficacious in my opinion was the repeated relational focus. In each case, the patient was struggling with a host of issues (career, school, love). Yet, the common thing for each patient was his or her struggle with people – how they could be attracted, the fear of lost relations, and, of course, the fear of appraisals. It is quite easy when discussing narcissistic patients to get caught up in the negative glare of their grandiosity. However, Mitchell's model keeps the focus on narcissism as a form of communication. The patient issues to the therapist an invitation to join him on the only terms that he knows; the therapist, in turn, is asked to tolerate this interpersonal style until both parties can figure out how to broaden it. With this in mind, a successful treatment would be measured by patients who leave

treatment able to maintain relationships in a broader, less rigid manner than when treatment started.

My focus on the patient's subjective experience is not a novel idea. Kohut (Kohut & Wolf, 1978) repeatedly encouraged the therapist to enter the subjective world of the narcissist. Yet, after extensive work with these patients and considerable reflection on their dilemmas, I felt that a specific task would help these patients concretize their problem and hopefully would give them some direction as they tried to feel their way out of their dilemma. Whether the task was to identify their contribution to feeling overburdened or to suffering from chronic disregard by others, or whether it was to answer for themselves *what is enough?* in an effort to help them differentiate themselves from an ambiguous notion of being "the best," these interventions appeared to move the patients closer to an appreciation of the price of their narcissistic illusions. These tasks gave the patients a sense of participation in their own narcissistic struggles.

With regard to the end-of-therapy assessment measurements, it should be noted that at the outset of treatment, Alex and Candace met DSM-IV diagnostic criteria for Narcissistic Personality Disorder, whereas Brian did not meet such criteria. At the end of treatment, Alex and Candace still met criteria for Narcissistic Personality Disorder, whereas Brian did not meet such criteria.

Further, as to individual measurements, a brief discussion of the format of and domains assessed by the NPI is warranted. The NPI has 40 questions; those who take the measure are instructed to select which one of a pair of statements best describes them. Responses carry a value of either 0 or 1, and the total score is derived from totaling all values (and, as such, a final

score will range from 0 to 40). The average test taker from a non-clinical population scores a 15.3.

In addition to a total score, the NPI measures seven individual domains. There is no articulated cutoff for the total score or for each subscale. According to Ehrenberg (1991), high scorers on the Authority subscale (for which there are eight questions) are held to be dominant, assertive, critical, and self-confident. High scorers on the exhibitionism subscale (for which there are seven questions) are held to be exhibitionistic, sensation seeking, extroverted and lacking in impulse control. High scorers on the exploitativeness subscale (for which there are five questions) are held to be hostile, insincere, manipulative and lacking in consideration for others. High scorers on the entitlement subscale (for which there are six questions) are held to believe that they are entitled to special treatment/privileges without an expectation of reciprocity. High scorers on the self-sufficiency subscale (for which there are six questions) are held to have inflated feelings of independence and to deny the need for reliance on others. High scorers on the vanity subscale (for which there are three questions) are held to be preoccupied with their physical appearance. High scorers on the superiority subscale (for which there are five questions) are held to have an inflated sense of their own self-importance and uniqueness.

In the pre-treatment NPI measurements, all three patients scored high (relative to a non-clinical normative sample) in the areas of superiority, entitlement, vanity and self-sufficiency. Alex scored high in the area of exhibitionism; Brian and Candace did not. Candace scored high in the area of authority; Alex and Brian did not. None of the patients scored high in the area of exploitativeness. This later finding is not surprising, as exploitativeness is often associated with

malignant narcissism (i.e. narcissism with antisocial traits), and none of the patients in the study evidenced antisocial traits.

Therefore, for the purpose of this study, when considering all patients together, the most consistent measures of a narcissistic personality disturbance could be found in the areas of superiority, entitlement, vanity and self-sufficiency. As for post-treatment measures, the patients uniformly had lower scores in the areas of superiority, entitlement and self-sufficiency. While these scores were lower, they still remained high relative to a normative sample. The patients' scores remained unchanged in the area of vanity.

On the NPI, Alex scored a 31 of 40. He scored particularly high in the domains of self-sufficiency, superiority, exhibitionism, vanity and entitlement. At the end of treatment, he scored a 25 of 40. There was a decrease in his scores in the domains self-sufficiency, superiority, exhibitionism and entitlement (but not vanity). On the NPI, Brian scored a 25 of 40. He scored particularly high in the domains of self-sufficiency, superiority, vanity and entitlement. At the end of treatment, he scored a 22 of 40. There was a decrease in his scores in the domains of self-sufficiency, superiority and entitlement (but not vanity). On the NPI, Candace scored a 32 of 40. She scored particularly high in the domains of authority, self-sufficiency, superiority, vanity and entitlement. At the end of treatment, she scored a 28 of 40. There was a decrease in her scores in the domains of authority, self-sufficiency, superiority and entitlement (but not vanity). The only statistically significant difference was between the total pretest scores and the total posttest scores; the mean difference between these total scores was M=4.33; s=1.528.

Although there was a decrease in the subscales for each patient, the change in each case was minimal; all differences in pretest subscores and posttest subscores were not significant. In each case, each patient still scored well above the average score of 15.3 for the non-clinical sample. Yet, each patient's end-of-treatment scores suggest broad movement toward a less rigid personality configuration with respect to one's narcissistic orientation when considering together all narcissistic domains measured by the NPI. Such movement was also seen through objective changes, as discussed below.

On the MCMI, Alex's base rate on the narcissism subscale was 75. This suggests that at the beginning of treatment that Alex could be said to have all of the features that define Narcissistic Personality Disorder as set forth in the DSM. At the end of treatment, Alex's base rate on the narcissism subscale was also 75. This score suggests that treatment had no impact on any of the domains of Alex's narcissistic personality disturbance. Brian's base rate on the narcissism subscale was 72. This suggests that at the beginning of treatment that Brain had some but not all of the features that define Narcissistic Personality Disorder as set forth in the DSM. At the end of treatment, Brian's base rate on the narcissism subscale was 68. This score suggests that treatment had a positive, albeit minimal, impact on Brian's narcissistic personality disturbance. Candace's base rate on the narcissism subscale was 82. This suggests that at the beginning of treatment that Candace could be said to have all of the features that define Narcissistic Personality Disorder as set forth in the DSM. At the end of treatment, Candace's base rate on the narcissism subscale was 76. This score suggests that treatment had a positive, albeit minimal, impact on Candace's narcissistic personality disturbance.

I argue that these patients evidenced improvement with regard to their narcissistic personality disturbance as demonstrated by (a) post-treatment changes to their MCMI scores in arenas other than narcissism (specifically, improvements seen in the clinical syndrome arenas of depression and anxiety) and (b) their objective behaviors. While the patients may not have experienced a significant reduction, for instance, in their sense of entitlement, these patients did evidence a softening of their sense of entitlement as well as less depressive symptoms and less anxiety symptoms. One could theorize that Mitchell's treatment model helped the patients to reduce the severity of their psychopathology by helping to the patient to (a) be more in touch with his/her genuine self and interests, perhaps thereby reducing some depressive symptoms, and (b) experience less interpersonal anxiety, perhaps thereby reducing their anxiety symptoms.

At the outset of treatment, Alex's base rate scores on the MCMI for the diagnostic scales for major depression and anxiety were 30 and 22, respectively. At the end of treatment, his base rate scores were 22 and 0, respectively. When comparing Alex's depression and anxiety before and after treatment, it is possible that Alex was underreporting his depressive symptoms on the posttest administration. Regardless, it appears that following treatment Alex suffered from fewer depressive and anxiety symptoms.

At the outset of treatment, Brian's base rate scores on the MCMI for the diagnostic scales for major depression and anxiety were 50 and 42, respectively. At the end of treatment, his base rate scores were 40 and 12, respectively. When comparing Brian's depression and anxiety before and after treatment, it appears that following treatment Brian suffered from less depressive symptoms and notably less anxiety symptoms.

At the outset of treatment, Candace's base rate scores on the MCMI for the diagnostic scales for major depression and anxiety were 60 and 22, respectively. At the end of treatment, her base rate scores were 22 and 12, respectively. When comparing Candace's depression and anxiety before and after treatment, it appears that Candace suffered from notably less depressive symptoms and less anxiety symptoms.

Further, with respect to his objective behaviors, at the beginning of treatment, Alex evidenced grandiosity, idealizing behavior and an inability to realistically assess his interpersonal relations due, in part, to a failure to engage in truly mutual relationships. At the end of treatment, Alex decided to remain in his band, despite its lack of commercial success, because he embraced that music was his true passion. He concluded that he did not need the external validation of commercial success to appreciate that his work was meaningful. During the course of treatment, he developed the ability to consider the function of his tendency to idealize others, and he was able to begin to consider that his relationships may not be built on what he could offer the other party. He was able to consider that he had value apart of what he was able to do for others. Further, he was able to remain in a romantic relationship and reveal some of his vulnerabilities. He was able to consider more fully his partner's aspirations for the relationship (which put Alex in the position of having to confront and tolerate his anxieties about the possibility that he may not be able to achieve such aspirations). Also he was able to see with greater clarity the true state of his relationships with his family members and to accept that his family members had limited interest in getting to know the genuine Alex. Finally, he was able at the end of treatment to discuss the therapeutic relationship and to articulate to me how much he valued our relationship.

At the beginning of treatment, Brian evidenced superiority, identity diffusion, an inability to identify his own interests, and an inability to effectively structure his own daily activities without assistance. At the end of treatment, Brian was better able to appreciate the function of his need to ally himself with a more confident other. While he still struggled with the identification of his own interests, he had begun to define himself and was able to remain in a romantic relationship despite its perceived limitations. In this respect, Brian was able to take a step back from the infinite possibility of his fantasy life and to appreciate that he needed instead to make decisions based in reality. In the midst of this struggle, Brian came to appreciate that he need not discard people once their flaws became evident; in a sense, he grew more able to hold at the same time the good and bad aspects of others, including his unfaithful father. Brian also grew more able to structure his time and to feel more autonomous and effective as a college student.

At the beginning of treatment, Candace evidenced grandiosity, counterdependency and an inability to appreciate that she was sacrificing her own interests in favor of external affirmation. At the end of treatment, Candace was able to understand the function of her drive to achieve as well as its limitations. Candace made the decision to leave a job that was causing her great distress and to consider new options. As she considered these options, she was able to look at each new employment opportunity and to identify which parts appealed to her narcissistic self and which parts appealed to her genuine self. Further, Candace was able to articulate the importance of her relationships and to look more closely at her tendency to affiliate with "people like [her]" in order to draw people to her as well her need for an illusion of sameness in order to avoid interpersonal anxiety caused by inevitable differences. Finally, she was able at the end of treatment to acknowledge the importance of the therapeutic relationship to her. She cried in the

final session and thanked me for helping her “more than I would ever know” through a “dark time.”

Do these results of the NPI and MCMI indicate that treatment was unsuccessful (at least as measured by these tools’ reliance on the DSM-III criteria for Narcissistic Personality Disorder)? First, as Masterson notes, “success in the psychotherapeutic treatment of personality disorders has been the result of extensive clinical experience, not refinements in research design.” (Masterson, 1989, p. 3) With this in mind, I would argue, based on clinical judgment and the patient’s objective behaviors late in treatment and after treatment, that treatment was successful in furnishing the patients with symptom relief as regards their depressive and anxiety symptoms as well as the ability to identify their narcissistic orientation and to consider its role in constricting their choices and relationships. These patients see the world through a narcissistic lens and will continue to do so until we can find a way to furnish patients with an entirely new lens. Barring that, we can give our patients the ability to play with the narcissistic illusions and to understand their origins and their restrictive utility. Further, we can try to confront our patients’ rigid choices by challenging them to look at the negative impact of these illusions on their relationships. Through such challenges, we can hope to guide our patients to broader, more fulfilling interpersonal choices.

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Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data

Characteristic	**Alex**	**Brian**	**Candace**	**Clinical Cut-off Score**
Age	30	19	26	--
Ethnic status	Caucasian	Caucasian	Asian	--
Job/Career Area	Musician/guitarist	College student	Management consultant	--
Presenting Problem(s)	Discontent secondary to his band's lack of commercial success	Disappointment with college experience	Depression secondary to work-related stress	--
Months in Treatment	19	24	11 (2x/week)	--
Total number of sessions	68	92	83	--

Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data (continued)

NPI at Beginning of Treatment	Overall Score: 31 Subscores: Authority: 4 of 8 Self-sufficiency: 6 of 6 Superiority: 5 of 5 Exhibitionism: 6 of 7 Exploitativeness: 1 of 5 Vanity: 3 of 3 Entitlement: 6 of 6	Overall Score: 25 Subscores: Authority: 3 of 8 Self-sufficiency: 5 of 6 Superiority: 5 of 5 Exhibitionism: 3 of 7 Exploitativeness: 1 of 5 Vanity: 3 of 3 Entitlement: 5 of 6	Overall Score: 32 Subscores: Authority: 7 of 8 Self-sufficiency: 6 of 6 Superiority: 5 of 5 Exhibitionism: 3 of 7 Exploitativeness: 2 of 5 Vanity: 3 of 3 Entitlement: 6 of 6	Average Score: 15. 3 (non-clinical population) No articulated cutoff for total score or subscores
NPI at End of Treatment	Overall Score: 25 Subscores: Authority: 3 of 8 Self-sufficiency: 5 of 6 Superiority: 4 of 5 Exhibitionism: 5 of 7 Exploitativeness: 1 of 5 Vanity: 3 of 3 Entitlement: 4 of 6	Overall Score: 22 Subscores: Authority: 3 of 8 Self-sufficiency: 4 of 6 Superiority: 4 of 5 Exhibitionism: 3 of 7 Exploitativeness: 1 of 5 Vanity: 3 of 3 Entitlement: 4 of 6	Overall Score: 28 Subscores: Authority: 6 of 8 Self-sufficiency: 5 of 6 Superiority: 4 of 5 Exhibitionism: 3 of 7 Exploitativeness: 2 of 5 Vanity: 3 of 3 Entitlement: 5 of 6	--

Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data (continued)

MCMI at Beginning of Treatment	Base rate for narcissism subscale: 75 of 115 Major Depression subscale: 30 Anxiety subscale: 22	Base rate for narcissism subscale:72 of 115 Major Depression subscale: 50 Anxiety subscale: 42	Base rate for narcissism subscale: 82 of 115 Major Depression subscale: 60 Anxiety subscale: 22	Base rate of 60 or higher indicates presence of some features that define the disorder; 75 or higher indicates presence of all traits that define the disorder; base rate of 85+ assumes primary diagnosis of Narcissistic Personality Disorder
MCMI at End of Treatment	Base rate for narcissism subscale: 75 Major Depression subscale: 22 Anxiety subscale: 0	Base rate for narcissism subscale: 68 Major Depression subscale: 40 Anxiety subscale: 12	Base rate for narcissism subscale: 76 Major Depression subscale: 22 Anxiety subscale: 12	--
PAI at Beginning of Treatment only	Axis II rule out of Personality Disorder NOS (with borderline, narcissistic and paranoid features) No narcissism subscale	Axis II rule out of Personality Disorder NOS (narcissistic features) No narcissism subscale	Axis II rule out of Narcissistic Personality Disorder No narcissism subscale	--

Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data (continued)

Met formal criteria for DSM DSM-Dx of Narcissistic Personality Disorder at outset of treatment - Yes or No) (see **)	YES *see below* 1. yes 2. yes 3. yes 4. yes 5. yes 6. no 7. yes 8. yes 9. no Total: 7	NO *see below* 1. no 2. yes 3. no 4. yes 5. yes 6. no 7. no 8. yes 9. no Total: 4	YES *see below* 1. yes 2. yes 3. yes 4. yes 5. yes 6. no 7. yes 8. yes 9. yes Total: 8	--

Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data (continued)

Met formal criteria for DSM DSM-Dx of Narcissistic Personality Disorder at end of treatment - Yes or No) (see **)	YES *see below* 1. yes 2. yes 3. yes 4. yes 5. no 6. no 7. no 8. yes 9. no Total: 5	NO *see below* 1. no 2. yes 3. no 4. yes 5. no 6. no 7. no 8. yes 9. no Total: 3	YES *see below* 1. yes 2. yes 3. yes 4. yes 5. no 6. no 7. no 8. yes 9. no Total: 5	

Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data (continued)

Objective Behaviors Indicating Psychopathology at the Beginning of Treatment	Grandiosity Idealizing behavior Inability to realistically assess interpersonal relationships	Superiority Identity diffusion Inability to identify own interests Inability to structure daily activities	Grandiosity Counter-dependency Inability to see conflict between sacrificing own interests in favor of external affirmation	--
Objective Behaviors Indicating Improvement at the End of Treatment	Decision to remain in non-commercially successful band Ability to consider function and limitations of idealizing behavior Decision to remain in relationship and consider directly his partner's hopes for the relationship Ability to tell therapist about the value of therapeutic relationship	Decision to remain in imperfect relationship Ability to appreciate difference between reality and fantasy as regards sexuality Ability to appreciate he need not just like or dislike someone; one person can hold both good and bad elements Ability to tell therapist about the value of therapeutic relationship in writing	Ability to leave prestigious job in favor of more satisfying work Ability to acknowledge the importance of relationships in her life Ability to tell therapist about the value of therapeutic relationship	--

Table 1

Title – Demographic and clinical characteristics of the three patients; assessment data (continued)

DSM-IV (APA, 2000): A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by **five (or more) of the following:

(1) has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

(2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love

(3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)

(4) requires excessive admiration

(5) has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

(6) is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends

(7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

(8) is often envious of others or believes that others are envious of him or her

(9) shows arrogant, haughty behaviors or attitudes