REVIEW

Narcissistic Interpersonal Problems in Clinical Practice

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Pathological narcissism is associated with significant interpersonal problems, which are unlikely to be acknowledged by narcissistic patients as clinical issues. Although a substantial clinical and theoretical literature deals with narcissism, a succinct overview of core narcissistic interpersonal problems is lacking, particularly in terms of their presentation in clinical settings. This article provides a descriptive overview of the major types of interpersonal problems associated with pathological narcissism: dominance, vindictiveness, and intrusiveness. We outline how these problems can manifest in patients' relations with others and in treatment situations. Clinical vignettes are provided to highlight the presentation of narcissistic interpersonal dysfunction in various types of clinical encounters, and to facilitate discussion of treatment implications. (HARV REV PSYCHIATRY 2011;19:290–301.)

Keywords: **interpersonal problems, narcissism, personality disorders, psychotherapy**

Pathological narcissism is deeply entangled with interpersonal problems, yet such problems may not be openly reported during treatment as issues of clinical concern. Although narcissistic patients may readily disclose symptomatic complaints, they may cover up associated psychopathology in an effort to avoid scrutiny and criticism. Alternatively, narcissistic patients might be so oblivious to the effects of their behaviors on others that they simply neglect to report on potentially significant interpersonal problems. The clinician's efforts to explore the patient's role in interpersonal scenarios can evoke a cantankerous or dismissive response, rather than reflective concern. Getting to know the patient with pathological narcissism therefore involves becoming familiar with specific problematic interpersonal behaviors, perhaps more so than with any other disorder.

The hand-in-hand nature of interpersonal dysfunction and pathological narcissism is reflected in the clinical aphorism that narcissistic individuals are not necessarily identified by how they feel, but according to how they make others feel—including treatment providers. Patients who present as arrogant, entitled, and dismissive can leave clinicians feeling befuddled, angry, insulted, and helpless. Such feelings, along with the intertwined narcissism and interpersonal dysfunction that engender them, figure centrally in the diagnostic and treatment-planning process. Individuals with narcissistic problems, although appearing haughty or indifferent, may suffer tremendously in terms of their core identity, self-esteem regulation, and dysphoric affects, especially if their actual abilities or achievements are widely out of step with their fantasies and expectations. The interpersonal dysfunction of narcissistic individuals may contribute not only to their own unhappiness, but also to difficulties in the lives of their loved ones. Difficulties interacting with others place narcissistic patients at risk for significant disruptions in their career, social, and family-life trajectories.

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Original manuscript submitted 10 January 2011; revised manuscript received 15 July 2011, accepted for publication subject to revision 6 September 2011; final manuscript received 28 September 2011.

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DOI: 10.3109/10673229.2011.632604

Stinson and colleagues[1] found that substance use, mood disorders, and anxiety disorders are highly comorbid with narcissistic personality disorder (NPD) (the term used in the successive versions of the *Diagnostic and Statistical Manual of Mental Disorders*; for more on this issue, see below). Although it is often one of these comorbid conditions that prompts the narcissistic patient to seek psychiatric treatment, Axis I disorders have been found to respond poorly to treatment when personality disorders are comorbid.[2] Thus, addressing narcissistic dysfunction may be necessary for many patients to obtain relief from other conditions.

This article will outline the interpersonal difficulties typically associated with pathological narcissism. Despite a large and broad conceptual literature, considerable uncertainty and debate lingers on in the field. In our experience, pathological narcissism is often underdiagnosed in mental health practice; it is common for clinicians not to recognize the links between problematic interpersonal behaviors and narcissistic dysfunction. Recent contributions have emphasized the importance of recognizing and addressing pathological narcissism in clinical practice.[3–6] There remains a gap in the literature, however, regarding the particular interpersonal problems experienced by narcissistic patients and how these difficulties are manifest in psychiatric settings. The revised criteria for NPD proposed for inclusion in DSM-5 are especially relevant in this context.[7] More generally, we will provide an overview of pathological narcissism and highlight some of the principal interpersonal problems that are likely to be encountered under different clinical circumstances. Case vignettes will be used to illustrate narcissistic interpersonal dysfunction, in order to prepare clinicians to respond appropriately to these clinical challenges. Finally, we offer some points to consider in addressing pathological narcissism, often considered a difficult-to-treat condition.

OVERVIEW OF PATHOLOGICAL NARCISSISM

Normal narcissism involves a healthy degree of self-investment—including positive self-regard, self-concern, and self-preservation—which is essential for achieving personal goals and is compatible with a capacity for empathy toward others.[8] Pathological narcissism, however, involves a distortion of self-investment, including an overinflated self-concept, an undeserved sense of entitlement, and compromised empathic abilities. Ultimately and somewhat paradoxically, extreme self-investment has a deleterious effect on the narcissistic individual, due in part to a diminished capacity for healthy relationships. Pathological narcissism is represented in the psychiatric nomenclature as NPD.

The DSM-IV-TR[9] definition of NPD emphasizes the presence of grandiosity and entitlement, fantasies of brilliance and success, intense envy, and lack of empathy and sensitivity toward others (see text box for diagnostic criteria).

DSM-IV-TR Diagnostic Criteria for Narcissistic Personality Disorder

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—that is, unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
6. Is interpersonally exploitative—that is, takes advantage of others to achieve his or her own ends
7. Lacks empathy—that is, 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

Source: American Psychiatric Association (2000).[9]

The proposed revision for DSM-5[7] includes NPD as one of six separate personality disorders within a hybrid categorical-dimensional classification of personality pathology. The revised criteria emphasize distorted or fluctuating identity, goals and values that are based on inflated or entitled self-appraisal, and limitations in empathy and intimacy that reflect self-regulatory concerns. Antagonistic personality traits characterized by self-centeredness and admiration seeking are also included in the DSM-5 proposal (see text box on next page).

Narcissism and Self-Regulation

Social and personality psychology research has emphasized the self-enhancement strategies of narcissistic individuals. Included here are their persistent, intrapsychic efforts to maintain an inflated sense of self through fantasies of

Proposed Revision to Narcissistic Personality Disorder for DSM-5

Significant impairments in self-functioning, in either:	
Identity	Excessive reference to others for self-definition and regulating self-esteem
	Exaggerated or vacillating self-appraisal (inflated or deflated)
	Emotion regulation that mirrors self-esteem fluctuation
Self-direction	Goal setting is based on obtaining approval from others
	Personal standards are unreasonably high, to see oneself as exceptional, or too low, based on a sense of entitlement
	Often unaware of own motivations
Impairments in interpersonal functioning, in either:	
Empathy	Impaired ability to recognize or identify with feelings/needs of others
	Excessively attuned to reactions of others if perceived as relevant to self
	Over- or underestimate own effect on others
Intimacy	Relationships are largely superficial, often to serve self-esteem regulation
	Constrained mutuality in relationships due to limited interest in others' experiences and predominance of a need for personal gain
Antagonistic personality traits, characterized by:	
Grandiosity	Feelings of entitlement, either overt or covert
	Self-centeredness
	Firm belief that one is better than others, and condescension toward others
Attention seeking	Excessive attempts to be the focus of others' attention
	Admiration seeking

Source: American Psychiatric Association (2011).[7]

brilliance and glory, overvaluing their role in successes, and externalizing blame for failures.[3] Such individuals see themselves as unbound by usual social norms and conventions, and as deserving success without diligence or effort. They also use interpersonal strategies to maintain their enhanced self-concept[3]—for example, by searching for opportunities to be in the limelight, inordinate boasting of accomplishments, and seeking to triumph competitively over others. Shallow interpersonal relationships are regarded as a consequence of these self-enhancement strategies.

Although research in trait narcissism has contributed to knowledge about narcissistic self-enhancement, this work has been hampered by a lack of representation of the clinically distressed narcissism seen in psychiatric settings.[10] From a clinical perspective, pathological narcissism is not necessarily defined by persistent self-enhancement, but by self-regulatory deficits that include self-enhancing features. In a recent review of the literature, Pincus and Lukowitsky[5] note that pathological narcissism "involves significant regulatory deficits and maladaptive strategies to cope with disappointments and threats to a positive self-image." In a review from a clinical perspective, Ronningstam[6] emphasizes unstable and fluctuating self-esteem—ranging from the grandiose to the insecure—as the hallmark feature of NPD.

Subtypes and Fluctuations

Two principle kinds of narcissistic dysfunction, though described with varying terminology, have appeared consistently throughout the narcissism literature. Cain and colleagues[11] distilled a multitude of descriptive labels from the literature into (1) grandiose themes and (2) vulnerable themes. The former refer to self-inflation, arrogance, and entitlement—reflecting intrapsychic regulatory processes such as fantasies of unlimited success and disavowal of negative self-representations.[5,11] By contrast, the latter refer to feelings of helplessness, suffering, and anxiety regarding threats to the self—reflecting inner feelings of inadequacy, emptiness, and shame.[5,11] The vulnerable aspects of narcissistic pathology have been confirmed in several empirical studies.[10,12–14]

Although many patients tend to exhibit more of one than another, fluctuation between grandiosity and vulnerability is typical, varying in accordance with experiences of success or failure and interpersonal acclaim or rejection. For example, a patient struggling with overt shame and inhibition might reveal previously hidden grandiosity upon receiving some encouraging external recognition. Likewise, feelings of profound inferiority and weakness may come to the fore—surprising those who thought of the individual as confident and self-assured—following an event of interpersonal rejection. The presence of self-regulatory deficits involving distorted or fluctuating self-esteem has been recommended, for DSM-5, as being more indicative of NPD than the grandiosity emphasized by DSM-IV-TR criteria.[15] The proposed changes to NPD in DSM-5 better reflect these self-esteem fluctuations and the compromised interpersonal functioning associated with them. While these revisions will

likely help in identifying narcissistic patients, clinical conceptualizations remain the primary means of illuminating the underlying dynamics of pathological narcissism.

Etiology and Psychodynamics

Several excellent reviews have summarized the differences and common ground between Kohut, Kernberg, and other theorists in conceptualizing the dynamic mechanisms of NPD.[16–18] Further examination of these mechanisms is beyond the scope of the present article. Nonetheless, some critical anchoring points are worth noting for our purposes. Shame—the experience of profound personal deficit—has been posited as a core affect of pathological narcissism.[19] Narcissistic personality functioning involves complex efforts at mastering shame-based affects and self-states, including: idealization of self or other,[19,20] perfectionism as an attempt to triumph over inadequacy,[6] and chronic self-defeat as a means of controlling one's own humiliation.[21] Envy may be linked with shame as a painful sense of being deprived of what others possess. Efforts to avoid conscious awareness of shame and envy include defensive devaluation, so that others are seen as having nothing worth desiring.

Denying normative needs for intimacy, dependence, and responsiveness can also serve to defend against envy.[4] At the same time, and somewhat paradoxically, narcissistic individuals can harbor a strong sense of entitlement, which may be expressed in relation to less aversive, superficial needs such as admiration and material gain. Infantile omnipotence, including the fantasy of merging with another, has been postulated as the origin of narcissistic entitlement.[22] In relation to shame, a pervasive sense of entitlement can be viewed as a form of compensation and restitution for early deprivation and humiliation.[23] Closely related to entitlement in this sense is the phenomenon of narcissistic rage. Kohut[24] distinguished competitive, goal-directed aggression from narcissistic rage, an aggression borne out of utter helplessness and shame. Narcissistic rage may operate covertly and chronically, in tandem with a sense of entitlement, as a means of aggressively restoring a damaged self.[25,26] Further affronts to narcissistic entitlement may stimulate severe, if not violent, rage in order to avert a dire enfeeblement of the self.

The oscillations of narcissistic dynamics create diagnostic challenges in that recognition of narcissistic pathology may not fully occur until there has been a change from one self-state to another. Understated self-enhancement and shame in a depressed patient, for example, are often too subtle or paradoxical to give the impression of a narcissistic disorder. It may take a shift into grandiosity or narcissistic rage for the clinician to be jolted into awareness of a full-blown pathological narcissism. Conversely, exhibitionistic features may be initially construed as mild traits associated with adaptive functioning, until a psychological affront shatters the patient into a painful state of narcissistic collapse. Some maladaptive self-regulatory mechanisms, such as fantasies of brilliance or tendencies to devalue others, can be discerned by listening to the patient's narrative. Narcissistic interpersonal problems, however, will also directly enter the clinical setting, providing clinicians with an additional, immediate medium for evaluating the patient's self-regulatory difficulties.

NARCISSISTIC INTERPERSONAL PROBLEMS

We now turn to a description of various interpersonal problems associated with narcissistic pathology, in order to identify signs of pathological narcissism where it might not otherwise be suspected, and to assist with understanding such phenomena when encountered in the treatment situation. Drawing from clinical research findings, our discussion will be oriented around the behaviors portrayed by the Inventory of Interpersonal Problems, a widely used instrument designed to assess problems in interpersonal interactions.[27] Several studies have found an association between pathological narcissism—particularly in grandiose form—and dominant, vindictive, and intrusive interpersonal behaviors.[11,12,28–30]

Dominance and Control

Individuals with NPD may feel a strong need to exert control over others. As a reflection of grandiosity and entitlement, domineering behavior may take the form of explicit demands for others to obey or conform to the individual's idiosyncratic standards. Family members, for example, may be forced into complying with strict rules of conduct, having to seek special authority for any kind of exceptional request. For example, one patient of ours insisted that his wife obtain his approval when selecting which outfit to wear each day. In workplace settings, domineering behavior may take the form of a "my way or the highway" kind of attitude when dealing with subordinates or peers: the person's demands are to be followed simply because that is what is desired, without regard for reason or due process. Dominant behavior is a blatant expression of grandiosity and entitlement: the individual's specialness permits him or her to call the shots. However, an additional message is sent out in this kind of interacting: that others are feeble and incapable. In this way, dominance and control can be a behavioral manifestation of defensive splitting and projection: intolerable self-states associated with weakness are continually assigned to others as the narcissist maintains an authoritative self-representation.

Harv Rev Psychiatry
November/December 2011

Alternatively, dominance may reflect a defensive position against unacknowledged fears of being either overpowered or rejected by others: the narcissistic individual may be preemptively taking control in order to avoid the humiliation of an anticipated defeat.

Although domineering individuals may initially impress others as being confident, take-charge types, those close to them eventually tire of being treated as though they are incompetent or invisible. In the treatment setting, dominance may also be expressed explicitly through demands for the therapist to provide special modifications to accommodate the patient. For example, the patient may insist on special fee or appointment-time arrangements. In group therapy, the patient might clamor for a personal exemption to one of the group rules or norms, and may even initially convince co-members that such an exemption should be provided. A more surreptitious form of dominance can also enter the treatment in the form of what Gabbard[31] describes as a "sounding board" transference pattern, where the patient barely allows the therapist to get a word in edgewise. Although the patient may initially appear to be adhering to the principle of free association, it becomes clear after a while that the patient has little interest in what the therapist might be thinking or feeling, and that the patient's verbal output serves to control the therapist. Feelings of anger, boredom, or disengagement may ensue for the clinician.[31] Therapists must remain alert to their feelings of being excluded as being similar to the feelings of other people in the patient's life. Alternatively, such countertransference feelings could reflect dissociated aspects of the patient's self-experience, perhaps related to the patient having felt excluded or controlled by narcissistic parents.

Vindictiveness

Vindictive interpersonal behavior can present as suspicious, vengeful conduct fueled by envy and resentment. In an acute, activated state, such behavior may take the form of narcissistic rage,[26] where narcissistic individuals feel compelled to enact vengeance in order to redress what they experience as an intolerable injury to their self-esteem. For example, one patient explained that he had to have the last word if anyone insulted him in any way: anything less than a compensatory strike toward the offending party would be experienced as a soul-crushing humiliation. The envy and shame evoked by the other person being in any kind of "one-up" position might, for some narcissistic individuals, feel completely unbearable. Some patients may have a sense of vindictiveness always at the ready, living out a chronic narcissistic rage.[25] Likewise, devaluation may be frequently employed by some patients to psychologically spoil what might be coveted, in order to defend against envy. One patient in group therapy would consistently find ways of offering backhanded compliments to each group member: no one—articulate speakers, successful professionals, parents with children—had anything that he would wish for. The more explosive variant of acute, narcissistic rage may also manifest in therapy, as when the patient storms out of the session after unleashing a torrent of verbal abuse onto the therapist.

Sometimes the therapist becomes the target of devaluation and vindictiveness, as the narcissistic patient subtly, but persistently, indicates a belief that the therapist is incompetent or inferior in some way. Gabbard[31] describes narcissistic patients' contemptuous transference patterns as often involving a long-standing envy of what they perceive the therapist to possess, including the capacity to be helpful to the patient. Devaluation averts a sense of inferiority through a defensive perception of the therapist as having nothing to offer. At times this attitude may erupt into a more pronounced denigration. Clinicians faced with such contempt in the transference must be prepared for a corresponding countertransference—the dread and resentment of being the object of denigration. In some instances, such countertransference may be defended against through an extra-nice, overly empathic reaction formation.[31] At other times, the therapist might start wondering silently about transferring the patient to a different therapist or treatment format. Consideration of the meaning of these reactions can help the clinician avoid acting on them in ways that could jeopardize the treatment, and may produce some clues regarding the internal dynamics of the patient. For example, the patient who repeatedly denigrates might be attempting to master an earlier childhood experience of a hostile, overly critical parent by forcing the therapist to occupy the role of hapless victim. Effective interpretation of these dynamics—linking the behavior in sessions with earlier interpersonal ruptures—can be challenging. Doing so may provide the patient with a sense of relief, yet at the same time may evoke further envy of the therapist's resources (in being helpful).

For some patients, the cycle of envy, devaluation, and understanding may need to be revisited many times over. For others, such as those designated by Kernberg[4,32] as having malignant narcissism, severe vindictiveness essentially prevents psychotherapeutic treatment. Malignant narcissism involves the regular use of aggression—including the sadistic defeat of the therapist—to maintain self-cohesion. When combined with antisocial features, psychotherapy is most likely contraindicated.[4,32]

Intrusiveness

Intrusive interpersonal behaviors often involve exhibitionistic displays that encroach on other people's "personal space" and that are intended to cultivate a sense of superiority

or to elicit admiration, along with a lack of sensitivity to the feelings of others. Although exhibitionistic behavior may demonstrate legitimate talents or skills, its deployment may be consistently ill-timed and lacking in consideration for how others might actually experience it. For example, one woman, an able singer, felt compelled to sing aloud at her daughter's music recitals, oblivious to her daughter's unease at being upstaged and embarrassed. Intrusive behavior can also consist of a less-exhibitionistic insistence on one's specialness. Frequent "name-dropping" of important people with whom the individual had a minor connection is one such example. Seemingly casual hints of one's specialness might be woven into conversations, or activities might just happen to be routinely organized around the individual to garner admiration. Individuals with intrusive tendencies often show a disregard for personal boundaries, feeling free to offer unsolicited wisdom to others, or to take for themselves what they feel entitled to. They fail to appreciate that such behavior engenders superficiality and distance in interpersonal relations, rather than admiration and affection.

Intrusive behavior may be one of the more persistent interpersonal patterns of narcissistic patients. For patients who completed an 18-week psychiatric day-treatment program, intrusiveness was the only interpersonal domain not to show a statistically significant change by the end of treatment.[28] Group therapy presents a range of opportunities for the narcissistic patient to act out intrusive and exhibitionistic behavior. The patient might begin the session with a longwinded, dramatic tale of his or her latest exploits, oblivious to the pressing needs of other members to explore issues of conflict and distress. When other group members do speak about some kind of personal tragedy, intrusive patients may shift the focus onto themselves with over-the-top tears of "sympathy." These patients might proffer unsolicited hugs to co-members and invite them to call after the session, ignoring the boundaries and norms set up by group leaders, who seem callous compared to the fervent altruism displayed by the patient. Boundaries may be likewise blurred in the individual treatment setting; the patient may prefer to treat the clinician more like a friend than a therapist. In therapy the priority of these patients may shift from exploration to cultivating admiration as they regale the therapist with examples of their accomplishments. Such a pattern may underscore the patient's disavowed longing for the therapist's love and approval. Similarly, a profound curiosity and inquiry into the therapist's life can also denote such yearnings, while at the same time shifting focus away from the patient's weaknesses and presenting him- or herself in more of a "friend" role. With respect to self-esteem, intrusive interpersonal behavior may serve to compensate for an unconscious sense of having little internally that might interest others. Patients may feel it necessary to insert themselves into other peoples' awareness in order not to experience a dreaded lack of recognition or admiration.

CLINICAL ENCOUNTERS WITH NARCISSISTIC INTERPERSONAL PROBLEMS

The common view of narcissism holds that such individuals feel so good about themselves that they do not seek treatment. In our view, however, clinical encounters with pathological narcissism are not uncommon, though they may not be identified as such. Ronningstam[6] identifies three circumstances in which the narcissistic patient presents for treatment: (1) an acute crisis precipitated by personal failure or loss, (2) an ultimatum from family, an employer, or the legal system, and (3) the patient's desire to change. The last circumstance may stem either from a sense of meaninglessness[6] or from symptomatic distress related to a comorbid Axis I condition.[33] We will now discuss how narcissistic interpersonal problems can manifest in each of the three clinical circumstances above. Composite case vignettes are presented with disguised identifying information. These examples are drawn from different clinical settings: individual psychotherapy, the initial consultation interview, and group psychotherapy, respectively. Finally, we will briefly highlight some clinical considerations involved in addressing narcissistic pathology.

The Acute Crisis

> Mr. A was a 21-year-old, high-achieving economics student who presented to the emergency department with serious suicidal ideation. He felt there was no point to remaining alive now that his girlfriend of two years had broken off their relationship. In addition to feeling adrift without her, he felt indignant at her having cruelly rejected him. After a brief hospital stay to de-escalate his imminent suicide risk, he was referred for outpatient services. He remained dysphoric, becoming consumed with rage upon imagining his ex-girlfriend dating other men. He revealed to the therapist that he had continued to pursue contact with her and, in emails laced with vaguely menacing and suicidal comments, repeatedly implored her to reconnect with him. After the police finally ordered him to cease these communications, he expressed the idea that he "might" commit suicide and leave a note implicating both the ex-girlfriend and the therapist in his decision to die. After carefully evaluating the potential suicide risk, the therapist conveyed to Mr. A that he was responsible for his own life but that his obviously intense suffering should be explored and that the therapist could help him do so.
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> The therapist also remarked to Mr. A on his capacity to think and learn, indicated by his academic success

Harv Rev Psychiatry
November/December 2011

to date. His suicide threats began to diminish. Mr. A became receptive to the therapist's invitation to examine the degree to which he had invested in the relationship with his now ex-girlfriend as a means of maintaining his self-esteem, which had been diminished throughout his childhood, partly due to having been bullied. Shortly after experiencing some relief, however, Mr. A indicated a reluctance to open up to the therapist, demanding to first know details about the therapist's personal life. He also expressed resentment at the therapist having other patients. After a planned vacation break, Mr. A failed to show up for his next session. When contacted by the therapist, Mr. A replied that he had found a new girlfriend, felt considerably better, and no longer saw any need for therapy.

In this vignette, the patient's interpersonal problems in romantic relationships are apparent. Mr. A's fragile sense of self contributed to his sense of entitlement that his ex-girlfriend accept him regardless of his own behavior. After she left him, his efforts at controlling her shifted between intermittent clinginess and overtly dominating and intrusive overtures, in the form of vague, manipulative threats. Furthermore, his dramatic suicidal fantasy seemed to be an attempt to exact revenge against his ex-girlfriend—a narcissistic rage response to his sense of fragmentation. The clinician was also brought into the expression of this fantasy, reflecting a mixture of vindictiveness—perhaps fueled by envy—and dominance in the sense of attempting to control or unbalance the therapist.

Dealing with suicidality in the narcissistic patient who is in acute crisis can be a formidable clinical challenge. For some patients, acute narcissistic crisis may be a core component in the "disarticulation of the self-representation"[34] that precedes serious suicidal intent or a sudden suicide attempt,[35] indicating a need for hospitalization. For other patients, suicide fantasies sometimes play a role in self-regulation by providing the patient with a reassuring sense of mastery in the face of narcissistic threat.[36] For still other patients, expressions of suicidality might reflect an unconscious invitation into countertransference enactments of rescue situations, sometimes with disastrous consequences.[37]

In an acute crisis the narcissistic patient usually displays significant vulnerable features, typically following an experience of failure, rejection, or loss. Mr. A felt a profound sense of humiliation at having disintegrated in the wake of his girlfriend's rejection. The prominence of such dysphoria may contribute to pathological narcissism being overlooked by clinicians intervening in acute crises. Grandiose features, discernible through interpersonal behaviors, may nonetheless remain operative as mechanisms to forestall a complete dissolution of the self. These features may be seen in efforts to control the therapist or obtain special treatment, or in expressions of devaluation and resentment toward the clinician. Understanding the function of such behaviors as narcissistic glue for a fragmented patient can help the therapist manage corresponding countertransference feelings and avoid potentially provocative interventions. Mr. A initially responded to the therapist's supportive and exploratory stance, which included limit setting (in relation to Mr. A's suicidal gestures) and overt validation of both Mr. A's distress and his strengths. Mr. A also considered the therapist's hypothesis regarding his compensatory investment of self-esteem in his ex-girlfriend, along with the devastating consequences of that dynamic. Although this intervention averted further acute deterioration and provided symptomatic relief, Mr. A disengaged from treatment once some narcissistic equilibrium had been restored. Unfortunately, such an outcome is not uncommon for narcissistic patients.[38] For some patients, premature termination may itself be a form of vindictive behavior; the fantasy of thwarting the therapist serves to defend against envy and dependency. Some patient-therapist dyads, however, are able to build upon the crisis-stabilizing alliance and transform it into a long-term exploratory therapy aimed at diminishing narcissistic pathology.

The Reluctant Patient

Mr. B agreed to attend a psychiatric outpatient clinic at the request of his wife, who had become increasingly concerned about his irritable moods and episodes of extreme anger. Upon becoming angry or frustrated, Mr. B would embark on a cleaning spree at home; the fervency of this effort led Mr. B and his wife to wonder if he suffered from obsessive-compulsive disorder. At other times, after having a bad day at work, Mr. B would pick out various flaws in his wife's way of managing the home, until a fight broke out between them. These issues had become especially problematic in the preceding few months, ever since the couple had had their first child; his wife insisted that he at least seek consultation. She attended part of the interview, bringing with her their infant son.

It was determined at the interview that Mr. B's cleaning "binges" occurred in the wake of shame-inducing interpersonal conflicts, rather than in response to obsessions about cleanliness. Restoring his home to a state of perfection seemed a concrete effort to restore his fragile sense of self after he had been criticized by coworkers. He had frequent clashes at his work in a meatpacking plant—which he described as being due to the failure of his employers and coworkers to recognize his superior abilities (though, in fact he possessed no greater qualifications than anyone

else there). He was somewhat more successful maintaining a sense of control at home—for example, by insisting that his wife have a meal ready for him every evening, and by feeling free to criticize her for failing to get things done according to his standards. Recently, however, he had become irritated by the fussiness of their baby and was expressing intolerance for the child's crying episodes. Indeed, their son began to cry during the interview, and Mr. B's wife attempted to soothe him. Mr. B erupted in visible annoyance: "I can't believe it! Can't you see that I'm trying to do an interview here? You should have known he would get hungry and fed him before we got here." The clinician attempted to discuss the stress of becoming new parents, the pressures of work, and Mr. B's reported strained relationship with his own parents. Further consultation was offered with the intent to offer psychotherapy, but Mr. B, having satisfied his wife's request, declined any further service.

Being "pushed" into treatment is difficult for many patients, but perhaps more so for patients with pathological narcissism. The fact that someone needs to insist that someone else obtain help is a reflection of that person's repudiation of any psychological difficulties. Treatment may be complied with but not seriously engaged in, due to an unwillingness to properly take on the patient role, with its attendant self-examination and vulnerability: "I'm only here because my wife wanted me to come—she's just too sensitive." Although Mr. B acknowledged his irritability as a real issue, his attitude and behavior conveyed the impression that he did not feel responsible for his problems. His entitlement—to special treatment from both his wife and his coworkers—was enforced by controlling interpersonal behaviors. When others failed to meet his entitled expectations, Mr. B engaged in compensatory attempts to restore his self-cohesion (though he was not aware of their nature as such), including through the retaliatory berating of others. One of the most difficult aspects of domineering, vindictive behavior such as we see here is the absence of empathy for those on the receiving end of it. The feelings of others, including close family members, are simply disregarded in favor of the narcissist's agenda. Mr. B was not able to consistently experience his wife as a person in her own right, but rather as someone who should fulfill his expectations. Likewise, Mr. B experienced his son's crying as an inconvenient nuisance, rather than as a signal that might evoke tender concern.

When brought to treatment by someone else, the narcissistic individual may be even more inclined to put his or her best foot forward and attempt to foster a positive image for the clinician. The patient may believe that the referring party (e.g., a spouse or employer) will be satisfied if the clinician can be convinced of the patient's normalcy and pleasantness. Consequently, the patient may exert maximal effort to keep problematic interpersonal patterns concealed from the interviewer. In the above case, the patient was cooperative and amiable with the therapist. Mr. B's experience of his wife's inattentiveness, however, proved to be too much for him to contain, providing the clinician with an in vivo demonstration of his reactive, vindictive interpersonal style.

Several hypotheses are available to explain Mr. B's narcissistic dynamics. He may have felt unconscious envy regarding his wife's capacity to give life and comfort to their infant child. He may have resented the fact that parenthood had deprived him of being the primary object of his wife's attention. Core shame affects—carried over from a childhood in which his father often humiliated him—may have been constantly susceptible to being triggered at Mr. B's workplace, where he often felt picked on by his supervisor. Thus, with an array of potential issues to explore, the clinician is challenged during the evaluation and engagement of the narcissistic patient. Which area might foster curiosity and engagement, and which might impinge upon the patient's self-esteem? A patient's controlling or vindictive stance can suggest to the clinician that the patient would likely not tolerate any intervention that could be construed as a criticism. The clinician could thus select a less threatening, more general area to explore in order to promote an alliance and a sense of trust. In our case, the therapist's framing of the issues in general terms as a phase-of-life difficulty was not enough to convince Mr. B that treatment could be either tolerable or useful.

Seeking Change

Mr. C was a middle-aged accountant who sought treatment in the aftermath of a failed extramarital affair. He had suffered mild to moderate depressive episodes in the past, and since the end of the affair, he had felt despair at having been rejected, as well as an increasing sense of life's emptiness. He was enrolled in long-term group psychotherapy, and during the first session he explained his recent circumstances. Mr. C told the group that he had become enraptured with a sexually provocative woman who, as he perceived in retrospect, had been intent on destroying him. Her eventual rejection of him sent him into a state of despair, along with dismay at having been deceived by her. He seemed to feel no compunction for having initiated the affair, in spite of his being married. Mr. C described his seduction as having been inevitable; that whoever was in this woman's presence would be powerless to resist her. He imagined the group leader himself would likely be seduced by her. There was little mention of his wife's feelings—only that she had not found out about the infidelity and that he had enjoined his teenage children to keep it

Harv Rev Psychiatry
November/December 2011

a secret. Group members were incredulous and irritated when they heard Mr. C present his plight. Several members sternly reprimanded him, prompting him to defend himself haughtily and threaten to leave the group. The group therapists intervened to curtail further criticism and to encourage the group to accept and listen to Mr. C.

Over time, Mr. C was able to develop an alliance with the group, largely through professing support for other members. At times, however, it appeared as though he was not really listening to them. Instead, Mr. C would offer lengthy soliloquies musing on the incomprehensibility of life and love. Consciously experiencing himself as benevolent and caring, he frequently gave advice to other members, though the advice itself often reflected only the superficial aspects of his own relationships. When other group members reported struggles in their personal relationships, he advised them to "pull the pin" and end the relationship as soon as possible. Confrontation by other group members resulted in Mr. C either ignoring the comments or becoming argumentative. Eventually, he revealed more about significant losses and anxieties throughout his life—for example, his having been chronically frightened as a child by his parents' constant fighting. Group members began expressing empathy for Mr. C, and in turn he became more open to their comments about his interpersonal interactions. Despite an ongoing penchant for advice giving, as therapy progressed Mr. C became more reflective regarding both his own issues and those of the group's co-members. He came to see that thrill-seeking activities, such as his affair, had served to enhance his self-esteem and provide a sense of enlivenment. Struggling with empty and anxious feelings in the group seemed to help Mr. C develop his capacity for tolerating such affects and for finding satisfaction in his work and relationships.

Patients with narcissistic pathology who seek to address long-standing difficulties are likely to have a more favorable prognosis than those who obtain treatment in crisis or under external duress. Nonetheless, their interpersonal problems are brought into the clinical situation. Mr. C exhibited a prominent intrusive interactional style in his external relationships and in the way that he related to group members. The circumstances surrounding his affair, as well as his interactions with his children, suggested an impaired sense of interpersonal boundaries. He seemed oblivious to his effect on others, both in carrying out his affair and in the manner in which he presented his situation to the group. Mr. C also proffered considerable advice to his co-patients, going against the group norm of helping others to explore and determine their own solutions. Furthermore, his advice—like his philosophical musings—often fell short of being in touch with the prevailing theme or issue.

An intrusive, boundary-impaired interactional style can reflect feelings of specialness and entitlement. Mr. C valued his opinions highly and felt compelled to share them with group members, seemingly with little idea of how they might be received. Occasional vindictive outbursts, however—for example, when his ideas were strongly challenged—hinted at the potential frailty of his inflated self-regard. The diminished frequency and inappropriateness of his advice giving over time signified a scaling down of his grandiosity. For some patients, intrusiveness can also reflect limited self/other differentiation: others may be valued more for their function to the individual than for their status as whole, independent persons. For example, in expressing his anxiety that his wife might find out about his affair, Mr. C was initially concerned mainly about the consequences for him, not about who she was (that is, his wife) and about the hurt she would suffer. Fortunately, his concern for her grew as his treatment progressed. He became able to reflect that he had used the excitement of the affair to ward off deeply buried feelings of anxiety and inferiority. He also realized that his ability to properly consider his wife had been compromised amid his self-regulation problems.

When Mr. C's grandiose efforts failed, the aggressive aspect of his exploitation was denied, split off, and projected onto the mistress. Reliance upon defensive splitting—necessary during infancy to distinguish positive and negative affect states—is thought to be associated with a poorly integrated sense of identity.[39] Mr. C exhibited difficulty in maintaining an integrated sense of identity as someone with a range of sometimes contradictory affects and experiences. He rejected early feedback from group members regarding his negative behavior because he saw himself as harboring purely wholesome intentions, notwithstanding his use of a hand-grenade metaphor to advise others on relationship issues. Eventually, however, the group was able to draw his attention to contradictory aspects of his self-experience, such as his hard-nosed advice to others alongside his portrayal of himself as a kind and benevolent person. Even later, they were able to hypothesize about the interactions between his sense of self and affects such as shame, boredom, and aggression. Consistent exploration of contradictory self-states are thought to lead to a more integrated sense of self and others,[4] as well as to the emergence of painful, but enriching, affects such as guilt and mourning.[39]

TREATMENT

Format

The majority of clinical reports on treating narcissism deal with individual psychotherapy and psychoanalysis.

Some consideration should be given to group psychotherapy since this setting provides a unique forum in which interpersonal problems can be readily experienced, observed, and modified—which is, of course, a central advantage of the heterogeneous interpersonal psychotherapy group.[40] Although group therapy is generally perceived as contraindicated for narcissistic patients,[41] some patients may be more suited to this format than to individual treatment, and a recent study demonstrated significantly improved interpersonal functioning among narcissistic patients in a group day-treatment program.[28] Some narcissistic patients demonstrate an "incapacity to depend" on the therapist;[39] vulnerable feelings such as dependence may be intolerably intensified in individual psychotherapy. By contrast, potentially thorny transferences are diluted in the group setting.

Group therapy confronts narcissistic patients with potential threats to self-esteem, such as shameful exposure, submission to established group norms, and envy of others. These threats may be balanced, however, by opportunities for narcissistic self-enhancement, which could become problematic if not attended to by group therapists. Lack of empathy and a sense of entitlement are not engaging characteristics and can potentially lead to the scapegoating of the narcissistic patient in group therapy, which occurred early in the treatment of Mr. C. Intervention from group leaders is likely required to maintain the supportive or "holding" function of the group and to ensure that feedback from group members remains constructive. For some patients, the social feedback offered by peers in group treatment may feel less threatening—and thus more accessible—than that from a therapist/authority figure.

Focus of Interventions

Regardless of treatment format, the potential for modifying pathological narcissism through interpretation and explanation has been a source of debate, in part because of the tendency of many narcissistic patients to filter out any nonsupporting feedback. In some respects, however, this debate has paralleled the general discourse within psychoanalytic theory regarding the mutative effects of insight-promoting interpretation versus the corrective influence of the therapy relationship itself. With respect to narcissistic pathology, differences in emphasis are clustered around Kohut's self-psychology and Kernberg's object relations approach.[16,18] Kohut's approach emphasizes the therapist's empathic recognition and respect of the patient's narcissistic needs, with the therapeutic relationship constituting an essential, restorative function for the patient known as "selfobject" experience.[20,42] The self-affirming qualities of the selfobject transference are maintained until they are internalized by the patient, thereby resulting in a diminished reliance upon narcissistic defenses. By contrast, Kernberg[4,39] focuses on the consistent confrontation and interpretation of split-off and contradictory representations of self and other. Interpretation functions to integrate these disparate aspects of the self, along with their associated defenses, as they are evoked in the transference.

Given the absence of clinical trials concerning NPD, an integrated perspective may be the most prudent approach, whether in group or individual therapy settings. Gabbard[43] notes that these different approaches may have more in common than their incompatibilities suggest and that they can be seen as reflecting different points of emphasis in relation to differences among patients. In a contemporary self-psychological account of treating narcissism, Lachmann[44] advocates for the primacy of relational factors such as humor, empathy, and heightened affect between patient and therapist. Lachmann's clinical discussion also illustrates, however, the pursuit of insight through the exploration of underlying narcissistic dynamics and early object relations. In our third vignette, sufficient support and empathy from the group was required in order for Mr. C to feel safe enough to handle confrontations and examine his particular self-regulatory mechanisms. Feedback regarding the effects of his interpersonal style helped Mr. C to modify his interactions and develop a deeper level of concern for others. Perhaps more so than with other conditions, clinicians addressing pathological narcissism should flexibly blend supportive/relational interventions and exploratory/interpretive interventions in a way that is individualized to each clinical encounter.

Empathy and Countertransference

One of the key ingredients in any clinical involvement with narcissistic patients is empathy. Self psychology emphasizes the importance of the clinician imagining himself or herself in the skin of the patient, especially in the treatment of narcissistic personalities.[20,26] Indeed, empathy itself has been thought to promote psychological strengthening for the patient. Empathy is also essential in attempting to understand the meaning of maladaptive interpersonal patterns in terms of the patient's fluctuating self-esteem, and in selecting the most appropriate corresponding intervention at any given time.

Countertransference—particularly the clinician's negative reactions to narcissistic interpersonal pathology—can be a formidable impediment to maintaining an empathic and constructive clinical encounter. Betan and colleagues[45] found that expert clinicians tended to report negative countertransference responses to patients with NPD, such as: "I feel annoyed in sessions with him/her," "I lose my temper

with him/her," and "I feel resentful working with him/her." As potential affronts to the therapist's sense of professional self, these reactions can signify impending difficulties in the treatment process.[46] If unchecked, problematic countertransference responses can lead to enactments such as the clinician becoming disengaged, hostile, or reckless with boundaries.

Containing countertransference has the potential to do more than simply avert disruptive clinician behavior. From a contemporary psychoanalytic perspective, countertransference can be analyzed in relation to its prospective meaning regarding both the patient's dynamics and the dynamics of the therapeutic relationship itself.[47] Thus, countertransference operates at a level beyond that of either an expectable response to challenging behavior or a triggering of the therapist's personal issues. Countertransference may represent aspects of the patient's inner experience that have been disavowed or split off, and then evoked in the clinician's emotional responses via interpersonal interactions.[39] For example, the therapist's chronic feelings of frustration toward a dismissive patient might be emotionally resonant with the patient's childhood experience of living with a neglectful parent. The patient's frustrated self-representation—defended against by domineering and intrusive behaviors—thus becomes manifest in the clinician's emotional responses.

At other times, countertransference may take on the qualities of a disavowed object-representation.[39] The therapist's wishes to prematurely terminate the therapy, for example, may reflect the attitudes of the patient's once-rejecting objects (caregivers). The patient's externalization of these dynamics into the therapist's emotional field might constitute a crucial test: can the therapist handle his or her ambivalence constructively, in a manner that signifies safety and acceptance to the patient? Doing so, by way of silently hypothesizing the meaning of the countertransference, may demonstrate the ultimate ineffectiveness of the patient's unconscious efforts to pressure others into rejecting him or her. Interpretation can then attempt to explore and clarify the role of narcissistic interpersonal patterns (and their interaction with therapist behaviors) in maintaining these defensive and self-regulatory processes.

Countertransference can also be conceptualized as a reflection of the patient's efforts at managing—through interpersonal interactions—a form of relatedness that may feel uncomfortable for the clinician. Narcissistic patients who are afraid of becoming vulnerable may unconsciously evoke feelings of boredom or detachment in the clinician. The challenge for clinicians is to maintain empathy for the disavowed needs and fears lurking beneath countertransference reactions, and to respond accordingly.[26] For example, a clinician who deals with aloof feelings by becoming excessively personable and self-disclosing might unwittingly disrupt the patient's experience of a necessary selfobject relationship with the therapist.

Countertransference and narcissistic interpersonal problems are complex, intertwined, and multilayered. On one level, the interpersonal problems associated with pathological narcissism function to maladaptively regulate self-esteem and to avert shame-based affects. On another level, narcissistic interpersonal dysfunction serves as a conduit for the expression of disavowed internal experience, picked up in treatment as countertransference. Ultimately, containing and understanding these interaction patterns can move therapy forward, allowing for the gradual dissolution of their necessity.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the article.

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