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Veiled and Vulnerable: The Other Side of Grandiose Narcissism

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Abstract This paper provides a consideration of a broadened scope of pathological narcissism, with particular attention towards the hidden and vulnerable aspects of this clinical phenomenon. The narcissism construct is briefly reviewed, along with contemporary issues in understanding the different presentations of narcissistic dysfunction. Selections from the theoretical literature are then explored in order to offer a nuanced conceptualization of the vulnerable side of pathological narcissism. Clinical implications of these perspectives are then discussed, along with clinical case material, to illustrate the presentation and treatment of narcissistic vulnerability.

Keywords Narcissism · Narcissistic vulnerability · Psychotherapy

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Introduction

Clinical social work has long recognized the challenge pathological narcissism has posed for theory and practice (Palombo 1975; Eisenberg Carrilio 1981; Mone 1983). Thirty years ago Eisenberg Carrilio (1981) wrote that "the average social work practitioner, who is confronted daily with the manifestations of the narcissistic age, must wade through complex psychoanalytic theorizing rife with disagreements that can be understood only if one has considerable background in the area" (p. 107). More recent social work literature confirms two assumptions: (1) that the problem of narcissism has not abated, and (2) the theoretical complexity, confusion and debate continue to flourish (Bennett 2006; Bliss 1999; Consolini 1999; Goldstein 1995; Hotchkiss 2005; Imbesi 1999; Sugarman 2006).

Despite the complexity and theoretical confusion, everyone is sure they know a narcissist when they meet one. The term is virtually ubiquitous in common parlance, referring to an arrogant, entitled, and ruthlessly self-absorbed person. Often the label is applied to those who annoy and irritate with a blatant self-importance, placing themselves above the bounds of ordinary social conventions. Accordingly, calling someone "narcissistic" has become a sophisticated way to issue a put-down. At the same time, modern media report on a rising tide of narcissism and rampant entitlement in contemporary society (e.g. Bunting 2009; Tierney 2011), an assertion that goes back at least to Christopher Lasch's (1979) *Culture of Narcissism*.

But is narcissism really so easily sighted? Is there only one prototypical form? No doubt the grandiose presentation described above is easily recognizable and largely uncontested in its descriptive presentation. However, our

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contention is that pathological narcissism is often veiled and vulnerable. That is, significant narcissistic problems may be obscured from easy detection as such, concealed by symptoms of depression, anxiety, work and relationship problems, and indeed by a more elusive presentation. This perspective is in stark contrast with both the commonly-held view of narcissism and the DSM-IV-TR (American Psychiatric Association 2000) version of narcissistic personality disorder (NPD), which essentially depicts a pervasive pattern of grandiosity, self-inflation, and arrogance.

Nevertheless, advocating for an expanded view of pathological narcissism is hardly novel. The psychoanalytic literature contains a proliferation of conceptual and clinical observations regarding different facets of narcissism. In spite of—or perhaps partially because of—this, there remains considerable confusion about the construct. Many generalist clinicians seem to continue to opt for a simplified, one-size-fits-all version of narcissistic dysfunction: the self-aggrandizing attention-seeker. However descriptively accurate this may be of some presentations, it ignores an essential component of narcissistic phenomena: vulnerable self experience. Recent contributions have challenged the DSM-IV-TR version on clinical, conceptual, and empirical grounds (see Cain et al. 2008; Pincus and Lukowitsky 2010; Ronningstam 2009; Russ et al. 2008), arguing for both a broadening of the NPD category and a condensing of the multiple labels in psychoanalytic circulation. Proposed revisions to personality disorder diagnosis for the upcoming DSM-5 had initially eliminated NPD as a distinct diagnosis, sparking considerable expert advocacy for its inclusion and revision (Ronningstam 2011; Shedler et al. 2010). The current proposal indicates the inclusion of NPD, along with criteria which acknowledge fluctuating self-esteem and reliance on others for self-definition (APA 2011). We consider the present paper to add weight to an expanded and nuanced model of pathological narcissism, with particular emphasis on clinical social work practice.

Accordingly, this paper affirms the importance of considering pathological narcissism in clinical practice. Our contribution to the literature is in two principal ways: (1) by broadening the focus of pathological narcissism to include significant attention to covert and vulnerable features, and (2) by highlighting select psychodynamic theories which add depth and clarity to the understanding of these more elusive forms of narcissistic phenomena. We believe that an expanded and nuanced conceptualization of narcissism can assist the clinician not only in working with patients who present with clear narcissistic problems, but also in discerning subtle yet considerable narcissistic dynamics amidst presentations of affective, anxiety, and relational concerns. Clinical case material will be used to illuminate the veiled and vulnerable aspects of pathological narcissism.

Pathological Narcissism

A brief overview of the concept of narcissism is warranted, due to a history of multiple usage and imprecise definitions (Pulver 1970). The term generally pertains to issues regarding self-esteem and interpersonal relations, usually denoting a relative degree of self-absorption and diminished concern for others. Healthy narcissism (sometimes referred to as normal narcissism) consists of a reasonable and measured capacity for sustaining positive self-regard. Considered an adaptive and crucial aspect of healthy functioning, this capacity entails a realistic appraisal of one's personal attributes coupled with a capacity for empathy towards others (Stone 1998). Accordingly, healthy narcissism is required for a sense of personal agency, the pursuit of ambitions, and the restoration of self-esteem following personal defeat. In contrast, pathological narcissism "involves *significant* regulatory deficits and *maladaptive* strategies to cope with disappointments and threats to a positive self-image" (Pincus and Lukowitsky 2010, p. 426; our italics). In other words, individuals with pathological narcissism suffer a lack of appropriate mechanisms for the healthy maintenance of positive self-regard.

Both healthy and pathological variants of narcissism are encompassed within a functional definition of narcissism, proposed by Stolorow (1975). Narcissism is thus conceived of as any mental activity which serves to "maintain the structural cohesiveness, temporal stability, and positive affective coloring of the self-representation" (Stolorow 1975). Implicit in this view is the notion of narcissism as a continuum phenomenon, from healthy and adaptive at one end of the spectrum, to pathological and severely maladaptive at the other. The question of whether narcissism is actually a continuous trait or whether a fundamental difference exists between healthy and pathological narcissism continues to be debated. This controversy is partially fuelled by assessment and methodological issues in the empirical research of narcissism (see Pincus and Lukowitsky 2010). Investigation of the adaptive and pathological dimensions of narcissism continues to demonstrate the complexity of the construct and its defiance of straightforward measurement and classification (Maxwell et al. 2011; Zeigler-Hill et al. 2011).

The Problems of Pathological Narcissism

The self regulation deficits in pathological narcissism can take on many forms. These problematic efforts at maintaining self-cohesion can broadly be categorized as (1) intrapsychic, the use of internal psychological mechanisms, and (2) interpersonal, the strategic use of interactions with others (Campbell and Baumeister 2006). Examples of

intrapsychic mechanisms include fantasizing about one's own brilliance, inordinately praising one's successes, and attributing all blame for setbacks to external circumstances. This could take the form of an inner attitude of specialness and entitlement for success, perhaps considering oneself to be above and beyond society's usual conventions and norms. Paradoxically, some such attitudes may revolve around personal failure, in that experiencing oneself as suffering may serve covert but powerful identity and self-enhancement purposes (Cooper 2009). Preoccupation with self-oriented attitudes can contribute to a neglect of investment in or poor judgement regarding important life projects, for example in education or career. Interpersonal aspects of self-enhancement can include efforts to obtain admiration from others, exploitation of others in ways to "get ahead", and attempts at defeating others who may be perceived as presenting a threat to the individual's self-representation. Such strategies may provide short-term benefits, yet with long-term psychological and social costs (Miller et al. 2007; Paulhus 1998). Among psychiatric patients, major interpersonal problems such as dominance, vindictiveness, and intrusiveness have been associated with pathological narcissism (Ogrodniczuk et al. 2009).

The fact that problematic self-enhancement strategies are central to the notion of pathological narcissism begs the question: why? What is it that necessitates these psychological and interpersonal manoeuvres—sometimes conducted in a frantic manner—that create such long-range problems for narcissistic individuals and those around them? Closer attention to the other side of narcissism—the veiled and vulnerable counterpart to grandiose display—can provide a compelling answer. *The self-regulatory deficit of pathological narcissism is not the grandiosity itself, but a secret fragile core that must be warded off from conscious awareness and prevented from discovery by others—and indeed from the self.* Maladaptive behaviors serve to protect this weakened part of the self, often with considerable success. When these efforts reach their limits or fail, the narcissistic fragility is exposed amidst a torrent of painful, dysphoric affect. In this state, patients with narcissistic problems are most likely to seek help. However, they may be less likely to obtain a correct diagnosis in many settings, due to a prominence of mood and anxiety symptoms and a lack of the overt grandiose features that make up the NPD criteria in DSM-IV-TR. The prospective inclusion of variable self-esteem in the proposed DSM-5 (APA 2011) criteria may promote detection of different presentations of NPD. In our view, however, the potential complexity of these presentations indicates an examination of the nuances of narcissistic vulnerability, in order that social workers competently identify and address their clients' narcissistic difficulties.

A Nuanced Narcissism: Beyond NPD

In a thorough review of the narcissism literature, Cain et al. (2008) distilled a multitude of descriptive labels of narcissism into two fundamental themes: (1) grandiosity, and (2) vulnerability. Empirical research has added support to a narcissistic subtype distinction (Pincus et al. 2009; Russ et al. 2008; Wink 1991). The grandiose theme encompasses such parallel terms as exhibitionistic, oblivious, phallic, manipulative, and extroverted. This theme emphasizes self-inflation, callousness, and fantasies of superiority. The vulnerable theme, on the other hand, refers to feelings of helplessness, suffering, and anxiety regarding threats to the self, and reflecting inner feelings of inadequacy, emptiness, and shame. Narcissistic vulnerability involves hypervigilance to insult, and excessive shyness or interpersonal avoidance in order to retreat from perceived threats to self-esteem.

Building on the review by Cain et al. (2008), Pincus and Lukowitsky (2010) further distinguish between types—grandiosity and vulnerability—and expressions of narcissism. Grandiosity and vulnerability may each be either overtly or covertly expressed. For example, themes of fragility and depletion may be predominant and overtly expressed, yet grandiose fantasies may hover covertly in the background. Likewise, overt arrogance can mask covert feelings of inadequacy (Pincus and Lukowitsky 2010). From this perspective, narcissistic "subtypes" may be more appropriately considered as states which operate in a dialectical and reciprocal manner. Although many patients might evince one or the other theme much of the time, the contrasting theme remains psychologically salient, albeit unexpressed and perhaps inaccessible to the patient's awareness. In this way, a degree of expressive fluctuation between grandiosity and vulnerability is likely for most narcissistic patients (Ronningstam 2009).

Efforts at researching and refining the concept of pathological narcissism can surely help to enhance its utility for clinical practice. However, as Cain et al. (2008) note, the field is far from unified in approaching the issue, particularly concerning the covert and fragile aspects of narcissism. Given the relative paucity of empirical knowledge regarding narcissistic vulnerability, the clinical social worker is left to explore a vast theoretical literature to guide their work with such complex phenomena. This literature indicates that narcissistic vulnerability varies in presentation, tone, and intensity. Furthermore, conceptualizations of pathological narcissism are themselves varied and sometimes hazy, even within an overall psychoanalytic perspective. In highlighting some of these theories, we are implicitly embracing this ambiguity and uncertainty, suggesting a nuanced and multi-perspective approach. Our goal is not to coalesce these contributions into a unified

theoretical entity; it is rather to evoke relevant ideas regarding what is perhaps a veiled, and therefore lesser seen, image of pathological narcissism. We begin with a brief review of Freud's seminal contribution and then highlight the theoretical shifts of Reich, Fairbairn, Winnicott, and Kohut as they pertain to the phenomenon of narcissistic vulnerability.

Early Conceptualizations

Although he wrote only one paper specifically pertaining to narcissism, Freud (1914/1957) brought the term and concept into psychoanalytic discourse with a descriptively rich treatise that pushed at the boundaries of his theoretical model at that time. Freud suggested that all individuals begin life in a state of primary narcissism, essentially absorbed in the fulfillment of bodily requirements and unaware of such gratifications being provided by a distinct and separate other. Development brings about awareness of others and the loss of omnipotent wish-fulfillment. Freud identified secondary narcissism as a compensatory process engaged in to redress this loss: the individual seeks a return to early infantile omnipotence. Thus, secondary narcissism involves a withdrawal of investment from relations with others, as a consequence of frustration. Although Freud indicated that an extreme degree of withdrawal constitutes severe disturbance, he noted that attenuated forms of secondary narcissism are within the range of normal and neurotic functioning. In this way, Freud suggested that narcissistic self-absorption is present in all of us to some extent. He also formulated the influence that narcissism exerts on important personal relationships, in that relationship partners may be unconsciously chosen to fulfill the demands of secondary narcissism, rather than for their unique and differentiated qualities.

While aspects of "On Narcissism" have since been critiqued—the concept of primary narcissism, for example, has largely been refuted (Balint 1968; Stern 1998)—Freud's contribution began to sketch out the interplay between self-esteem, interpersonal relations, and narcissistic reactions to frustration. This was further extended by Reich (1960) in her conception of narcissism as a system of self-esteem regulation. Reich viewed narcissism as a normal phenomenon which becomes pathological under conditions where the self is especially vulnerable, either to the effects of frustration or to the demands of a severe ego-ideal. Shifts of investment from others to the self are therefore compensatory processes to protect against vulnerability and depression. Reich stressed the oscillating nature of pathological narcissism, considering self-absorption and grandiosity as exaggerated defensive measures against intolerable states of self-conscious anxiety and inadequacy.

Reich viewed grandiose features as regressive efforts at binding a self threatened by loss of self-esteem, threats to bodily intactness, and castration anxiety. Under severe threat, reality testing and self-other boundaries are weakened, and a withdrawal from objects becomes necessary in order that the self may continue to function at all. Narcissistic individuals are thus caught in a cycle of building themselves up and tearing themselves down, in a largely solipsistic effort to retain a degree of personal intactness, and to discharge the aggression stimulated by frustration and narcissistic injury.

Vulnerability and Internal Objects

Fairbairn (1952) also focused on states of withdrawal from others. His elaborate theoretical model, constructed around his study of schizoid phenomena, highlighted the essentially narcissistic problem of being locked into one's own psychology (Ogden 2010). Certain features of his formulations speak directly to the veiled and vulnerable aspects of narcissistic psychopathology, and aspects of these have been incorporated into Kernberg's (1984) object relations model of personality pathology, a comprehensive account emphasizing narcissism's internal structure and its aggression-derived features. Fairbairn's emphasis on object relations has also been integrated into clinical approaches for narcissistic disorders, such as those of Masterson (1981) and Rinsley (1989).

According to Fairbairn (1952), the developing individual seeks to maintain the powerful caregiver-infant bond—including the psychological sense of it—at any cost. When this relationship is fraught with turmoil or trauma the child must find a way to uphold the tie to their parent(s) by assuming that a defect in their own self is responsible for the negative experience. For the dependent child, it is preferable to cast him or herself as a defective unit under the care of ideal parents, rather than face the idea of being under the care of capriciously neglectful or savage parents. Fairbairn suggested that this tie to an internal "bad object" becomes tenaciously embedded within the personality structure, and because it prevents abject desolation: any kind of object is better than none. Preserving this bond requires an enduring representation of the self as shameful and bad, and subject to persistent criticism from a negative "internal saboteur" representation. At the same time, the individual engages in fantasies of omnipotence—grandiose compensations—and a withdrawal from objects as a partial remediation of this bleak situation (Fairbairn 1952). Thus, applying Fairbairn's model to pathological narcissism accounts for compensatory grandiosity, vulnerable "internal saboteur" experience, and—beneath it all—a further vulnerability that would ensue upon the loss of this latter identification with the bad object.

Fairbairn noted that patients who had suffered from early traumatic interactions tended to bring their fears—essential of being retraumatized—into subsequent interpersonal relations, with genuine closeness being avoided in favour of superficial or distant relations (Bacal and Newman 1990; Fairbairn 1952). Others are solipsistically experienced more as aspects of internalized early relations than as they actually are. At times this may involve the other as an idealized yet illusory tantalizer, or as someone who is almost certain to reject and humiliate. These projected, fantasied interpersonal experiences ensure that the true qualities of others remain obscured, with a resultant barrier to real relatedness. Only an acceptance and integration of these internal objects, and the circumstances which produced them, can pave the way for others to be experienced more deeply, and for who they actually are (Bacal and Newman 1990; Ogden 2010).

The True Self

It could be argued that, as aspects of narcissistic pathology are both "veiled and vulnerable", so too is the truest part of the psychological self. Most of us hold at least some aspect of our self in reserve, to be known intimately only by those closest to us, if at all. However, for the most part we can feel a sense of aliveness in being our "self" throughout a range of situations and interactions. Winnicott (1971) suggested that this is only possible through the incipient self having experienced a certain degree of adequate environmental provision. The caregiver's adequate "holding" of the infant—both physically and metaphorically/psychologically—is considered the cornerstone element in helping the infant to feel secure, alive, and integrated. A vital aspect of holding is the mother or father's sense of the infant as a subjective self who requires the parent to relinquish her or his own individual needs in order to facilitate the infant's unfolding sense of being and aliveness (Ogden 2004). This process requires the parents' tolerance of negative features of infant care and the inevitable ruptures in the caregiver-infant relationship (Winnicott 1971).

Caregivers' responses to the child's demands—inconvenient cries of hunger, outbursts of anger—play a crucial role in determining the nature of the child's experience of self. An intolerable level of failure in holding, such as the chronic imposition of the parents' needs over the child's, conveys to the child that his or her world has no place for the expression of the "true" self (Winnicott 1956). The true self that might have developed, but which instead experienced intolerable frustration, is protectively covered over by a psychological exoskeleton in order to comply with the demands of the external environment. The development of the "false self" bears some correspondence to the development of pathological narcissism as a shield for a thwarted, vulnerable core. The false self shields the true self from further impingement, at a price of severe diminishment of the capacity for creativity, depth, and intimate relationships (Winnicott 1956, 1971). Feelings of tenderness, dependence, and weakness—all potentially induced in a range of interpersonal scenarios—could threaten to expose and further injure the neglected inner core of the personality.

In Search of a Selfobject

Heinz Kohut also emphasized the sensitivity to injury and self-cohesion experienced by patients with narcissistic vulnerability. His writings placed narcissism as an essential component in the development of the self, and a product of deprivation from necessary narcissistic experiences (Kohut 1968; Kohut and Wolf 1978). Kohut's work produced a renewed interest in pathological narcissism, as well as a theoretical extension of psychoanalytic theory known as self psychology, thinking that quickly found its way into clinical social work literature on narcissism (Consolini 1999; Elson 1986; Goldstein 1995; Mone 1983; Palombo 1975). According to self psychology, pathological narcissism involves an early, emotional malnourishment of the self that results in chronic disturbances of affects, self-concept, and behaviors. Echoing Winnicott's concern with a facilitative environment, Kohut regarded certain parental responses as essential to the unfolding of healthy narcissism and a vigorous self. Mirroring experiences consist of caregiver responses which confirm for the child their own sense of greatness and vitality—a parent's beaming face as the child takes their first steps, for example. The child also needs to be able to idealize their caregivers: experiences of identifying and merging with parents who are calm, effective, and reliable. These experiences, known as "selfobjects," are deemed essential to the sustenance of the self (Bacal and Newman 1990).

Arguably the heart of Kohut's self-psychology, selfobject relations consist of experiences of responsiveness which evoke and affect the sense of self (Bacal 1990), and which are normal requirements in varying degrees throughout the life course. Chronic, traumatic frustration of selfobject needs results in an inability to reliably internalize positive selfobjects, leading to feelings of deficiency and emptiness (Kohut and Wolf 1978). Associated with this is a sense of profound shame and a propensity for the self to become fragmented upon future disruptions. Pathological grandiosity then develops to compensate for this sense of vulnerability and defectiveness (Morrison 1983), masking feelings of weakness with the transient glow of being superficially admired. Rather than pursue mature, affirming relationships, which carry the threat of mutual vulnerability and dependence, the individual may seek shallow

encounters to provide a cursory form of selfobject experience.

Implications for Treatment

Patients with narcissistic vulnerabilities hold significant challenges for treatment as their defences resist exposing vulnerabilities, resist feelings of dependence, resist mourning, and indeed resist being known. Fairbairn (1952) regarded the resistance to real relatedness as the most challenging aspect of treatment, with the achievement of a "real" relationship—one less burdened by toxic inner bonds—as the ultimate goal of psychotherapy. In Fairbairn's model, narcissism constitutes a living of life mainly in one's own mind (Ogden 2010), and the therapist seeks to gradually break through this system. This is accomplished by initially allowing herself to be cast with attributes of the patient's internal object world. At the same time, the therapist provides an experience of acceptance and interest—a "good object" experience—guided by an understanding of the tenacity of toxic inner bonds and narcissistic relatedness. The therapist's actual behavior, reflecting concern and acceptance, is the crucial element in addressing the fears associated with the patient's closed system (Bacal and Newman 1990; Ogden 2010). This includes helping the patient with the frightening realization that psychotherapy involves "being cured by the hair of the dog that bit them": a close relationship involving the activation of dependency needs and the awareness of those original conditions which drove them into repression (Bacal and Newman 1990, p. 153).

Many patients with narcissistic difficulties seem to struggle simply to maintain a generative therapeutic alliance, let alone a "real relationship" with the therapist. Gabbard (2009) described vulnerable narcissists as having a tendency towards hypervigilance, bringing with them a transference pattern of mistrust, sensitivity to rejection, and a corresponding tendency to elicit irritation in their therapists. Other patients with such vulnerability may conceal their concerns about losing face, instead injecting a level of superficiality into the consulting room in order to prevent depth and closeness. Consideration of Winnicott's false self construct can be useful in this regard: such patients' false self is in overdrive, protecting a fragile core from being evoked in the treatment situation. As one patient revealed, "it's like I have a wall, and it just comes down and closes, keeping everybody out. Even with you, you might reach the courtyard, but you won't get past the wall". Since the false self develops in accordance with the demands of the environment, rather than the innate expression of the true self, there can be various forms in which it can manifest in therapy. It can thus be useful to remember that a patient who bores, irritates, or confuses the therapist may simply be functioning at such a level, understandably protecting the true self.

According to Winnicott, the growth-promoting and integrating effects of a holding environment are required in order for false-self patients to benefit from traditional psychotherapeutic interventions. We should make clear that this does not suggest a directly physical holding, but rather a psychosocial milieu consisting of the therapist's mental activity and corresponding verbalizations. A large part of this mental activity involves an attitude of unobtrusiveness, reflected by the therapist's prioritizing of the patient's sense of time over that of their own (Ogden 2004). The therapist must essentially maintain an ongoing, steadfast sense of the patient's need to use the therapy as a holding environment, within which the true self might resume a process of gradually emerging. Interventions oriented around confrontation and interpretation may feel like impingements to the patient—interruptions to the process of "becoming"—provoking narcissistic vulnerability rather than providing for its maturation. Winnicott (1971) felt that effective holding promotes the development of the capacity for mutuality and creative fantasy, phenomena that are often stunted in pathological narcissism. Successful therapy affords the patient the ability to "create" the therapist within (in fantasy), and thus take over some holding environment functions for him or herself.

Kohut and Wolf (1978) outlined the need for certain transferences, such as the mirror and idealized transferences, to be maintained (rather than analyzed) as they meet the patient's needs for specific selfobject experiences. The selfobject relationship in psychotherapy has since been conceived of more broadly in terms of its function as an essential bond centered around the optimal responsiveness to the patient's needs (Bacal 1990). More than a basic working alliance, the selfobject relationship is a dyad-specific bond that the therapist contributes to through a range of potential activities, depending on the selfobject needs of the patient at any given time. At times the patient's sense of self may best be maintained through a supportive listening or mirroring stance, while at other junctures, empathic confrontation might be the most affirming selfobject response. As the therapeutic selfobject relation becomes reliable to the patient, interpretive work can take place in order to understand the impact of past selfobject failures. According to Bacal (1990), the patient's sense of basic entitlement to the responsiveness of the therapist—in contrast to clamorous demands for narcissistic gratification—is a key outgrowth of an adequate selfobject experience in psychotherapy. Over time this bond counters earlier feelings of enfeeblement and desolation, and is eventually internalized and represented as a sense of a strengthened self.

A common thread among the above conceptualizations of treatment is the notion of the therapeutic situation providing some form of developmentally ameliorative experience. Contemporary psychoanalytic theorizing has increasingly shifted from debate regarding the primacy of interpretation and insight versus the necessity of corrective experience, toward a position that recognizes the centrality and interconnectedness of both of these key aspects of treatment (see Eagle 2011). Although further discussion of this issue is beyond our scope, a balancing of interpretation and experiential provision can be at least implicitly located in the formulations of Winnicott, Fairbairn, and Kohut.

Case Presentation

Richard was a 23 year old cabinet-maker who was referred for outpatient mental health service due to serious suicidal ideation. Having previously attempted suicide once before, Richard was started on antidepressant medication in an effort to relieve depressive symptoms and ego-dystonic intrusive thoughts that he might involuntary harm other people. He was preoccupied and disturbed by the thought that he may at his core be a "psychopath" or a "monster", and that he might end up in a federal prison someday. In addition to continuing his medications, Richard was offered interpersonal group psychotherapy.

Background

Despite a supportive relationship with his girlfriend, Richard described having had interpersonal difficulties, including a sense of having been excluded from peer groups. He also indicated having difficult interactions within his family, including a chronically strained relationship with his father. His father was an often unemployed alcoholic who was prone to mood fluctuations and outbursts of anger and contempt. He had often felt he needed to intervene in order to protect his mother, whom he felt was kind but somewhat distant and needy. At the same time, he yearned for his father to provide him with the praise that was reserved for his younger brother, an accomplished hockey player.

Group Therapy

Although initially anxious about being in group, Richard soon felt a positive alliance with the other members. He impressed the therapists as being an introverted but thoughtful young man, using the sessions to consider some of the family dynamics issues which may have contributed to his depressive and anxious affects. He also seemed interested in assisting other group members in their own self-understanding. A common and often fluctuating occurrence in group therapy is resistance. One day, this was evident for at least a few of the members. Richard spoke up and berated the group: "come on you guys, this is frustrating! I haven't said anything about it until now, but it seems like I've been waiting around for ages for everyone else in this group to catch up with me. I've been getting so many insights and new thoughts, and everyone else seems to be just wasting time!" Although in retrospect Richard had been describing elements of narcissistic vulnerability for some time, it was this outburst of grandiosity that most strikingly alerted the therapists to his core narcissistic problems. These were further elaborated in his disclosure of fantasies of prevailing over others and winning admiration.

Individual Therapy

After 10 months of group therapy, having reported some symptomatic relief, Richard announced that his new job would prohibit him from further attendance. He returned to the clinic a few months later to commence individual psychotherapy, an offer that had been extended due to more flexible scheduling of sessions. Over time he increasingly revealed material that suggested severe narcissistic vulnerability. He described anticipating an intense sense of shame whenever he was due to see his father, both at potentially being belittled by him and also at the mere fact of this man *being* his father. As a child Richard had felt considerable embarrassment at his father's outrageous and discriminatory attitudes, which the father sometimes acted out in public by verbally accosting others and behaving inappropriately. Despite this, he maintained a longstanding sense of envy over the special relationship that his brother seemed to enjoy with their father. As Richard increasingly revealed his shame and resentment regarding his relationship with his father, the therapist sought to reflect back to him the urgency with which he must feel in eliminating such feelings. The therapist also silently observed that, in developing a bond with the therapist and expressing vulnerable emotional material, Richard was indeed attempting to forge a new way of handling his narcissistic problems. Richard seemed aware of the sharp contrast between the therapist's efforts to be reliable and empathic, and his experience of his father's foolhardy and hurtful capriciousness. A selfobject relationship had formed, from which he appeared to draw a sense of strength—often simply through the anticipation of having a session within a given week.

Vulnerable themes were also evident in Richard's fluctuating self-representation. Media reports about crime troubled him, evoking the feeling that he was inevitably and secretly a social deviant, destined for punishment and

negative notoriety (yet he never engaged in criminal behavior). In contrast, veiled grandiose features continued to function as a secret glue that supported his self cohesion, at times serving to restore him in the wake of significant vulnerability. He described having a longstanding sense of being destined to live an extraordinary life, including fantasies of becoming famous. Sometimes he would make subtle disparaging remarks to his girlfriend, despite acknowledging the unfailing support she provided him. During conflicts he insisted on standing his ground and having the last word.

Occasionally, Richard described reactive interpersonal responses that alarmed the therapist. He issued withering verbal attacks, or threats of violence, to anyone who even jokingly insulted him. Although the therapist felt a corresponding urge to reprimand him, the focus was instead brought to the barely-accessible vulnerability that motivated his rage: for Richard, not striking back spelled utter enfeeblement. Empathizing with this state of mind seemed to foster Richard's curiosity about his reactions. Links were developed between the shame he internalized in response to his father's outbursts and his contemporary reversal of this dynamic when under threat. Gradually, Richard became better able to modulate his responses to narcissistic injury, likely as a result of repeated efforts to empathize with and explore his vulnerability. Eventually this exploration extended to the therapy relationship itself.

Throughout much of the course of therapy, Richard had reverently referred to coming "here"—to a place, rather than to a person—as being extremely helpful to him. In self-psychological terms, this reflected a need for an idealized selfobject experience. The therapist, though somewhat uneasy about being the object of persistent admiration, chose not to examine this further until Richard had strengthened his capacity to handle interpersonal difficulties. Eventually, however, the issue of screening out the therapist's presence as a real person was brought up for exploration. Richard expressed his fear in seeing the therapy as a relationship between two individuals: that he would need to submit to the therapist's grandiose needs, or else be rejected. He later revealed that he had held back on disclosing certain anxieties, out of a fear that they would sadistically be used to humiliate him. Empathic discussion of these fears and their putative origins as aspects of his "true self" seemed to strengthen Richard's trust in the therapy and his growing reflectivity.

Transformation

As therapy progressed Richard noticed longer periods of time elapsing between episodes of intrusive thoughts. The themes of these thoughts were periodically analyzed with respect to negative internal representations, including that of himself as a shamed social outcast. Analyzing his vulnerability in the context of parental empathic failures was also a key aspect of the therapy. Perhaps of greater significance, however, was the therapist's acceptance—despite Richard's fluctuations between grandiosity and shame—of Richard's sensitivities and selfobject needs. Holding this in mind promoted an atmosphere whereby Richard could express shame-ridden anxieties, acknowledge the pain of lacking an idealizable father, and recognize grandiose attitudes through which he had attempted to compensate for these experiences. Eventually his intrusive thoughts virtually disappeared. Imagined conversations with his therapist seemed to help him to handle psychological threats between sessions. Gradually this took the form of a capacity to reassure himself, without having to act out aggressively. Richard realized that living an "ordinary" life was a worthy enough goal, and his grandiose fantasies abated such that he could develop his actual vocational trajectory. At the same time, he developed an expanded sense of concern and guilt regarding the impact of his actions on those around him.

The reliability and empathy of the therapy relationship took on a selfobject quality for Richard; simply attending and expecting the therapist's responsiveness seemed to provide a degree of self regulation. This situation, however, also fueled unconscious fears about becoming overly dependent on the therapist. At times this was acted out by not attending, as if to prove his autonomy, and at other times dealt with through defensive fantasies. His self-admonishment about dependence on the therapist—an aspect of Fairbairn's (1952) internal saboteur—eventually diminished as he integrated his early experiences of selfobject failures with his use of the therapist in such a way. Along with this came a developing sense of the therapist as a real person with whom he could experience vulnerable and tender feelings without being shamed. As the therapy drew to a close he expressed some disappointment that it was he who had to initiate this ending. He had harboured the wish that the therapist would usher in the termination by issuing him a "gold star" in recognition of his substantial progress. He had indeed made such progress, yet clearly—and expectably—some residues of narcissism remained.

Conclusion

Richard's initial clinical presentation had consisted mainly of depressive and anxiety symptoms. Significant narcissistic problems became apparent as the therapy process unfolded. His troubling intrusive thoughts were thematically colored by a sense of badness: a terrifying sense of being the worst kind of person imaginable. He was

exquisitely sensitive to having this sense of self evoked by others in the form of criticisms or rejections. Grandiose features—visible only intermittently—were also coupled with Richard's vulnerability, serving to protect him from fully experiencing a deeply embedded sense of shame and inadequacy. Interpretive exploration seemed to gradually allow him to better understand how repeated problematic relational experiences—particularly his relationship with his father—had contributed to negative self and object representations. He began to understand how these were then being evoked and re-experienced in his interactions with others. Perhaps most importantly, however, the consistency, acceptance, and responsiveness of the therapeutic relationship seemed to provide an experiential milieu which afforded changes to his inner representational world.

In our view, contemplation of the narcissistic elements in patients' affects and experiences can promote treatment efforts that go beyond symptom relief. Indeed, as the vignette illustrated, affective and ideational symptoms may not adequately resolve unless narcissistic vulnerability is sufficiently attended to. Holding an appreciation for the fragile, less-visible aspects of this self experience can open pathological narcissism up for empathic exploration in clinical work. In turn, clinical social workers may need to open themselves up to a nuanced view of their own narcissistic vulnerabilities, those which may be evoked by difficulties encountered in treating narcissistic patients (Buechler 2010). Those patients who fail to respond to initial helping efforts, or whose vulnerability gives way to aggravating behavior, may indeed impact our own sense of self-cohesion and esteem. The clinician must strive to hold in mind the patient's narcissistic vulnerability—their fears and injuries—during such moments, and at the same time manage their own narcissism. A nuanced perspective on narcissism thus presents both a demanding challenge and a reward: an ever-searching effort to perceive, understand, and respect the most vulnerable aspects of the self, both for our patients and ourselves.

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