

THIS ISSUE:

Narcissistic Personality Disorders: Part 1

Otto F. Kernberg, MD

Guest Editor



The narcissistic personality disorder presents, clinically, at three levels of severity. The mildest cases, who appear “neurotic,” usually present indications for psychoanalysis. They typically do consult only because of a significant symptom, which seems so linked to their character pathology that anything but the treatment of their personality disorder would seem inadequate. In contrast, other narcissistic patients at that level present symptoms that may be treated without an effort to modify or resolve their narcissistic personality structure. All of these patients seem to be functioning in general, except they typically present with significant problems in long-term intimate relationships and in long-term professional or work interactions.

A second level of severity of illness of narcissistic personalities reflects the typical syndrome with all the various clinical manifestations. These patients need treatment for their personality disorder, and here the alternative between

standard psychoanalytic treatment and psychoanalytic psychotherapy depends on individualized indications and contraindications. A third level of severity of narcissistic personality disorder functions on an overt borderline level. In addition to all the typical manifestations of narcissistic personality disorder, the patient also presents general lack of anxiety tolerance, of impulse control, and a severe reduction in sublimatory functions (that is, in his capacity for productivity or creativity beyond gratification of survival needs). These patients usually show severe and chronic failure in their work and profession, and chronic failure in their efforts to establish or maintain intimate relations. At this same level of severity, another group of patients may not show overt borderline features, but present significant antisocial activity, which may place them in the same category as those who function on a borderline level.

All of these severely narcissistic patients may respond to a psychoanalytic,

transference-focused psychotherapy, unless, for individualized reasons, this approach would seem contraindicated, in which case a more supportive approach or cognitive behavioral approach might be the treatment of choice.¹ Patients whose antisocial behavior is predominantly passive and parasitic present less of a threat to themselves and to the therapist than do those others who present severe suicidal and parasuicidal behavior, or violent attacks against others. Aggression against others or self is typical for antisocial behavior of the aggressive type, particularly when these patients fulfill the criteria for the syndrome of malignant narcissism. The syndrome of malignant narcissism includes, in addition to the narcissistic personality disorder, severe antisocial behavior, significant paranoid trends, and self-directed or other-directed aggression.

Let us review the dominant features of the narcissistic personality disorder as typically represented particularly at the second or intermediate level of severity.²

about the guest editor

Otto F. Kernberg, MD is Director, Personality Disorders Institute, The New York Presbyterian Hospital, Westchester Division; Professor of Psychiatry, Joan and Sanford I. Weill Medical College of Cornell University; and Training and Supervising Analyst, Columbia University Center for Psychoanalytic Training and Research.

The work reported in this paper was supported by the Borderline Personality Disorders Research Foundation and its founder, Dr. Marco Stoffel, to whom the author wishes to express his profound gratitude.

1. Pathology of the self. These patients show excessive self-centeredness, overdependency on admiration from others, prominence of fantasies of success and grandiosity, avoidance of realities that are contrary to their inflated image of themselves, and bouts of insecurity disrupting their sense of grandiosity or specialness.

2. Pathology of the relationship with others. These patients suffer from inordinate envy, both conscious and unconscious. They show greediness and exploitation of others, entitlement, devaluation of others, and an incapacity to depend on them (in contrast with ongoing need for admiration from others). They show a remarkable lack of empathy with others, shallowness in their emotional life, and a lack of capacity for commitment to relationships or goals.

3. Pathology of the superego (conscious and unconscious internalized value systems). At a relatively milder level, patients evince a deficit in their capacity for sadness and mourning. Their self-esteem is regulated by severe mood swings rather than by limited, focused self-criticism; they appear to be determined by a “shame” culture rather by a “guilt” culture, and their values have a childlike quality. More severe superego pathology, in addition to defective mourning, entails chronic antisocial behavior and significant irresponsibility in all their relationships. In their lack of consideration of others there is no capacity for guilt or remorse for such devaluing behavior. A particular syndrome, reflecting severe superego pathology and characterized by the combination of narcissistic personality disorder, antisocial behavior, aggression (directed against self and/or others), and marked paranoid trends, is the syndrome of malignant narcissism.

4. A basic self state of these patients is a chronic sense of emptiness and boredom, resulting in stimulus hunger and the wish for artificial stimulation of af-

fective response by means of drugs or alcohol that predisposes to substance abuse and dependency.

Patients with narcissistic personality disorder may present typical complications of this disorder, including sexual promiscuity or sexual inhibition, drug dependence and alcoholism, social parasitism, severe suicidality and parasuicidality, and, under conditions of severe stress and regression, the possibility of significant paranoid developments and brief psychotic episodes.

TREATMENT OF THE NARCISSISTIC PERSONALITY DISORDER

The indications for various modalities of psychoanalytic and other modalities of treatment vary with the severity of the illness and the individual combination of particular symptoms and character pathology. The general techniques of standard psychoanalysis and psychoanalytic psychotherapy have to be modified or enriched by specific approaches to deal with the narcissistic transference/countertransference binds.³

A core issue for narcissistic patients is their incapacity to depend on the therapist, because such dependency is experienced as humiliating. Such fear of dependency is defended against with attempts to control the treatment.^{4,5} Clinically, this takes the form of the patient's efforts of “self analysis,” as opposed to a collaboration with the therapist leading to integration and reflection. These patients treat the therapist as if he were a “vending machine” of interpretations, which they then appropriate as their own, at the same time being chronically disappointed for not receiving enough or not the right kind of interpretations, unconsciously dismissing everything they might learn from him. For this reason, treatment often maintains a “first session” quality over an extended period of time. Narcissistic patients show themselves as intensely competitive with the

therapist and are suspicious of what they consider his indifferent or exploitative attitude toward them.

Conversely, narcissistic patients may also show a defensive idealization of the therapist, considering him as “the greatest,” but such idealization is frail and can rapidly be shattered by devaluation and contempt. It also may be part of omnipotent control, in that these patients unconsciously attempt to force the therapist to be always convincing and brilliant, as befitting their grandiosity, but not superior to them, as that would generate envy. The patient needs the therapist to maintain his “brilliance” in order to be protected against the patient's tendency to devalue him, which would leave him feeling totally lost and abandoned in the treatment.

A major feature involved in all these manifestations is the patient's conscious and unconscious envy of the therapist, the patient's consistent sense that there can only be one great person in the room, who necessarily will depreciate the other, inferior one, which motivates the patient to try to stay on top with the risk of feeling abandoned because of the loss of the devalued therapist. The envy of the therapist is an unending source of resentment of what the therapist has to give. This may take many forms. The most important one is the envy of the creativity of the therapist, of the fact that he can creatively understand the patient rather than providing him with pat, cliché answers that can be memorized by the patient. Also, the capacity of the therapist to invest in a relationship, which the patient is aware he does not have, is envied. The most important consequence of conflicts around envy are negative therapeutic reactions: typically, the patient feels worse following a situation in which he clearly acknowledged having been helped by the therapist. Acting out of the envious resentment of the therapist may take many forms, such as

playing one therapist against another; an aggressive pseudo-identification with the therapist by playing the therapist's role in a destructive interaction with third parties, and the patient's constructing a view that it is he himself alone who is the cause of his progress.

Chronic suicidal tendencies of narcissistic patients have a premeditated, calculated, coldly sadistic quality, which differs from the impulsive, "momentarily decided upon" suicidality of ordinary borderline patients.⁶ The projection of persecutory object representations onto the therapist in the form of severe paranoid transferences also may become predominant, as well as a form of narcissistic rage that expresses the patient's sense of entitlement as well as his envious resentment. "Stealing" from the therapist may take the form of learning his language in order to apply it to others rather than to the patient himself, as well as the syndrome of perversity, which is reflected in the use of what is received from the therapist as an expression of his concern and commitment and as a way of expressing aggression against others. In other words, perversity is a malignant transformation of what the patient received from the therapist.

Narcissistic entitlement and greedy incorporation of what the patient feels is denied to him may take the form of apparently erotic transferences, demands to be loved by the therapist, or even efforts to seduce the therapist as part a general effort to destroy his role. These are severe complications and are different from the erotic transferences of higher-level, neurotic patients.

When improvement occurs typically, the severe envy diminishes, and the capacity for gratitude gradually emerges both in the transference and in extratransferential relations, particularly in the relationship with intimate sexual partners. Envy of the other gender is a dominant unconscious conflict of narcis-

sistic personalities. The decrease of the envy of the other sex permits a decrease of unconscious devaluing attitudes toward intimate partners and the capacity for maintained love relations improves. Narcissistic patients may become more tolerant of their own feelings of envy without having to act them out, and, with increased awareness, tendencies toward defensive devaluation gradually decrease in this process. The development of more mature feelings of guilt and concern over their aggressive and exploitive attitudes indicates the consolidation of the superego, as well as the deepening of their object relations. At times, however, that integration may imply such a severity of the now integrated but sadistic superego that these patients may experience severe depression at a point where improvement of their character pathology is evident.

Under optimal conditions, patients who had experienced dominant psychopathic transferences (their conviction of the therapist's dishonesty, or the direct expression of conscious dishonesty and deceptiveness on these patients' part) over an extended period of time may shift into paranoid transferences against which the psychopathic transferences had been a defense. Such paranoid transferences (related to the projection of persecutory object representations and superego precursors onto the therapist) may shift into depressive transferences, as the patient becomes able to tolerate ambivalent feelings and recognize his experience of both intense positive and negative feelings toward the same object.⁷

Perhaps the transference development most difficult to manage is that of patients with an extreme intensity of aggression, which may present itself in the form of almost uncontrollable suicidal and parasuicidal behavior outside the sessions and in chronic sadomasochistic transferences in the sessions. In

the latter, the patient sadistically attacks the therapist over an extended period of time, clearly attempting to provoke him to respond, in his countertransference, in the same way, only to then accuse the therapist of being aggressive and destructive. In all of this, the patient experiences himself as the therapist's helpless victim. This development of a secondary masochistic relation to the therapist may be followed in turn by self-directed aggression in which the patient accuses himself exaggeratedly of his "badness," only eventually to revert again to an extremely sadistic behavior toward the therapist, thus re-initiating the cycle. Here the technical approach involves pointing out to the patient these patterns of experiencing self and other as either an aggressor or his victim in the transference, with frequent role reversals.

Another manifestation of severe aggression in the transference is the syndrome of arrogance, quite frequently present in narcissistic personalities functioning on an overt borderline level: the combination of intense arrogant behavior, an extreme curiosity about the therapist and his life, but little curiosity about himself, and "pseudo-stupidity."⁸ The latter symptom consists in a lack of capacity to accept any logical, rational argument: the main defensive purpose of this entire syndrome, on the patient's part, is to protect himself against the awareness of the intense aggression that controls him.

Although these transference developments may evolve in any treatment modality, the advantage of psychodynamic psychotherapies and psychoanalysis is that they may permit resolution of these transference manifestations by means of the interpretative focus. In contrast, supportive and cognitive behavioral treatments may control and reduce the most severe effects of these transference developments on the relationship with the therapist, but their continued uncon-

scious control of the patient's life continues to be a major problem. Supportive and cognitive behavioral approaches may reduce, by educational means combined with a general supportive attitude, the inappropriate nature of the patient's interactions at work, or in a profession. However, work at this level is not sufficient to modify the incapacity of these patients to establish significant love relations in depth and to maintain gratifying intimate relations in general. Also, the difficult transference developments may undermine supportive or cognitive behavioral approaches.

There are references in the psychoanalytic literature, particularly within the Kleinian approach, which indicate successful treatment with non-modified analytic approaches of some severely ill narcissistic patients.⁸⁻¹¹ The work of Steiner refers to the analysis of narcissistic patients, whom he designates as presenting a "pathological organization." Hinshelwood¹² points to the use of this term within Kleinian literature for "inaccessible personalities." One problem, however, is that the overall description of such patients in that literature usually lacks sufficiently detailed information about their general symptomatology and personality characteristics. In addition, the subtle and convincing descriptions in the Kleinian literature of particular interpretations of the transference of these patients conveys a sense of effectiveness of these interventions that leave open, however, the overall question of the long range effectiveness of the treatment, of indications, and contraindications.

TYPICAL PRESENTATION OF 'IMPOSSIBLE' PATIENTS

Usually, negative prognostic features become evident during the initial evaluation of patients. Despite careful history taking and assessment, important data emerge only after treatment has begun, altering our initial diagnostic and prog-

nostic impressions. There are, however, typical manifestations of what may eventually prove as insurmountable obstacles to the treatment, which may be identified in the initial evaluation.

Chronic Work Failure in Contrast with High Educational Background and Capacity

These are patients who have worked for many years below their level of training or capacity and often drift into a "disabled" status so that they must be cared for by their families (if they are wealthy) or the public social support system. Such a chronic dependency on the family or on a social support system represents a major secondary gain of illness, one of the principal causes of treatment failure. These patients are high consumers of therapeutic and social services. However, were they to get well, they would no longer qualify for the supports that maintain their existence. These patients come to treatment not because they are interested in improving, but to demonstrate to the social system their incapacity to improve and, therefore, their need for ongoing social support. Because they are usually required to be in some kind of treatment in order to get supportive housing, Social Security benefits, disability benefits, etc., they go from program to program, therapist to therapist. Michael Stone, a senior member of our Personality Disorders Institute at Cornell, has concluded that if a patient were potentially able to earn by working at least 1.5 times the amount of money that he is receiving from social support systems, there may be a chance that eventually he will be motivated to work again.¹³

This condition of work failure may merge with grandiose fantasies of capacities and success that remain unchallenged as long as the patient does not become part of the work force. The rationalization of this pattern of social

parasitism may include a fantasized profession or talent the patient has and that nobody has recognized as yet: the unknown painter, the inhibited author, the revolutionary musician. Often such a patient is perfectly willing to enter treatment as long as somebody else pays for the treatment, and will abandon it the day when payment is no longer available, even if there existed the possibility of continuing the treatment if the patient were willing to take on employment.

The therapeutic approach to such cases needs to include the reduction or elimination of the secondary gain of illness. Clinically, I would point out to the patient that an active involvement in work and its related interactional experiences and/or accepting conceptual-responsibility for financing the treatment are essential for the treatment to help the patient, and that such an engagement is a precondition for the possibility of carrying out a psychoanalytic psychotherapy.

Depending on the situation, I might give the patient a period of time to achieve this goal, with a clear understanding that should it not be possible to achieve it, treatment will be interrupted at that point. This condition constitutes a limit setting that will become part of the treatment frame, and therefore, require interpretation as part of its transference implications from the beginning of the treatment. These interpretations may focus on the unconscious motivation for the refusal of work, the importance of the gratification of secondary gain, the resentment the patient may experience toward the therapist's threat to the patient's equilibrium, and the self-defeating aspects of the patient implied in his denying himself the possibility of well being, success, self respect, and enrichment of life linked to a potentially successful and creative engagement in a work or a profession.

[continued on p. 164]

...[continued from p. 110]...

Pervasive Arrogance

This symptom may dominate in patients who, while recognizing that they have significant difficulties or symptoms, obtain unconscious secondary gain of illness by demonstrating the incompetence and incapacity of the mental health professions to alleviate such symptoms. They become experts in the field of their suffering, diligently research the internet, check out therapists for their background and orientation, compare their merits and shortcomings, present themselves for treatment “to give the therapist a chance,” but consistently obtain an unconscious degree of satisfaction in defeating the helping profession. They may suffer from symptoms such as chronic marital conflicts, bouts of intense depression when threatened with failures at work or profession, anxiety, and even chronic depression. Such severe, chronic depressions respond only “partially” to whatever psychopharmacological treatment they receive (and even to electroconvulsive treatment, which sometimes, is questionably recommended for patients with chronic and severe characterological depression). The combination of a psychotherapeutic treatment with psychopharmacological treatment may temporarily leads to a surprising improvement, which in these patients’ view is due to “the medication alone”; the psychotherapeutic treatment is not helpful and becomes unnecessary (the medication “does not work anymore”) later.

The sudden shift from frail idealization to complete devaluation of the therapist may occur at any point. Sometimes, a treatment of many months’ duration that seemed to be progressing satisfactorily is unexpectedly disrupted because of an intense onslaught of envy of the therapist, which triggers a radical devaluation of him. The initial evaluation of these patients usually reveals an arrogance,

which may evolve into grossly inappropriate behavior and rudeness in some cases, or be thinly masked by a surface facade of appropriate tactfulness, in others. This arrogance has to be differentiated from the syndrome of arrogance,⁸ which coincides with intense affect storms in the transference and which, in the context of a psychoanalytic psychotherapy where the patient’s relationship with the therapist is firmly established, has a better prognosis.

The technical approach to these patients must include a tactful confrontation and systematic analysis of the defensive functions of arrogance in the transference, pointing out to the patient in the process, which given his emotional disposition, there is a risk that the treatment will end prematurely because of the devaluation of the therapist. Typically, the patient fears, by projective identification, that the therapist has a similar depreciatory disposition toward the patient, and therefore, if the patient’s superiority is challenged or destroyed, he will be subject to a humiliating devaluation by the therapist. Whenever possible, it is very helpful to interpret the unconscious identification of the patient with a grandiose parental object, which often is at the bottom of this characterological disposition. The identification with such a grandiose and sadistic object seems to bolster the patient’s self-esteem by protecting the patient’s sense of superiority and grandiosity. However, the patient is actually submitting to an internalized object that stands against any real involvement in a relationship with somebody else that might be helpful and is profoundly hostile to the dependent and true relational needs of the patient.

The Expression of Dominant, Unconscious, Self-destruction

This group of patients includes what even the experienced clinician as extremely grave conditions. These are

patients with severe, repetitive, suicidal attempts of an almost lethal nature, suicidal attempts that happened “out of the clear sky,” often carefully prepared over a period of time, and even engineered under the eyes of concerned therapists. Chronic self-destruction may also manifest itself, in addition to such suicidal attempts, by self-destructive behavior in what potentially might become gratifying love relations, a promising work situation, and the opportunity for professional advancement. At times, these patients are seen in early years of adolescence or young adulthood, when many opportunities lay still ahead of them in life. Other cases come to the therapist’s attention much later, after many failed treatments, with a gradual deterioration of the patients’ life situation, and an apparent search of treatment as a “last resort,” which may induce a sense of hopefulness in the therapist, who believes the patient’s life may still change. At times, the patient may very openly state that he or she is committed to death by suicide, defiantly challenging the therapist to see whether he can do anything about it. Sometimes this defiant challenge comes to a head early, at the time of setting up of the treatment contract, with the patient refusing to commit himself to such contractual arrangements. Usually the family background of these patients evinces severe and chronic trauma, including sexual or physical abuse, an unusual degree of family chaos, or a practically symbiotic relationship with an extremely aggressive parental figure.

If antisocial features complicate the picture, the patient may be deceptive about suicidal tendencies, and the chronic lack of honesty and a psychopathic type of transference may preclude any possibility to build up a helpful human relationship with a therapist. For example, one of our patients would ingest rat poison for suicidal and parasuicidal purposes. She was able to smuggle rat poison

into the hospital and developed internal hemorrhages. While steadfastly denying the ongoing consumption of rat poison to the therapist, her blood tests showed a continuous increase in the prothrombin time. Psychotherapeutic treatment had to be interrupted because of the obvious unwillingness or incapacity to adhere to the treatment contract that committed her to stop ingesting rat poison as a precondition for ongoing psychotherapy. André Green¹⁴ has described, in connection with the syndrome of the “dead mother,” the unconscious identification with a psychologically dead parental object. The unconsciously fantasized union with this object justifies and rationalizes the patient’s complete dismantling of all relationships with psychologically important objects. In fact, the onset of this patient’s ingestion of rat poison was coincident with a visit to her mother’s gravesite.

Unconsciously, the patient may deny the existence both of others and the self as meaningful entities. This radical dismantling of all object relations may constitute, at times, an insurmountable obstacle to treatment. In other cases, the self-destruction is more limited, being expressed not in suicidal behavior proper, but in severe self mutilation that repetitively punctures the psychotherapeutic treatment and signals the unconscious triumph of the forces in the patient that promote self-destruction as a major life goal. Such self-mutilation may lead to the loss of limbs or severely crippling fractures but stop short of the risk of immediate death.

This disposition may emerge in a patient’s relentless effort to provoke the therapist into an aggressive disposition or action against the patient, to transform the relationship into a sadomasochistic one. At the same time, this reaction usually is accompanied by efforts to transform the assumedly “bad” therapist into a “good” one, to

transform the persecutory object into an ideal one, an effort that fails because of the relentless need to reenact this sadomasochistic transference by repetition compulsion. In contrast with patients whose main motivation is a total dismantling of the object relationship, here there is an implicit recognition that the therapist has attempted to be helpful: in fact, this experience is what triggers this particular negative therapeutic reaction. If the therapist is not provoked to an extent that may lead to a disruption of the treatment, the consistent interpretation of this fantasy and unconscious provocation may resolve the impasse.

The technical approach to this entire group of patients implies to take seriously the danger of the patient ending up destroying himself physically. The patient’s self-destruction is an ongoing threat to the treatment, making this danger a selected theme of the interpretive work from the very beginning of treatment. The therapeutic contract that is negotiated with the patient is intended to establish the minimal preconditions that will assure that the treatment not be used as a “cover story” for providing the patient with further freedom or incentives for self-destructive action. This may not be an easy task as the therapist has to make it clear that the treatment will not proceed if these minimal conditions for assuring the patient’s survival are not met. Such conditions may include the patient’s commitment to immediate hospitalization if suicidal impulses are so strong that the patient believes he will not be able to control them, or the absolute commitment to stop behaviors that threaten the continuation of treatment and/or the patient’s survival.

Antisocial Features

Here we are dealing with the aggressive infiltration of the pathological grandiose self, both in cases where this is expressed mostly in a passive/parasitic

tendency and in cases where it takes an aggressive/paranoid form (in the syndrome of malignant narcissism). All cases of narcissistic personality disorder with significant antisocial features have a relatively reserved prognosis. Patients with the syndrome of malignant narcissism are at the limit of what we can reach with psychoanalytic approaches within the field of pathological narcissism. The next degree of severity of antisocial pathology, the antisocial personality proper, has practically zero prognosis for any psychotherapeutic treatment.

Paradoxically, the very severity of the aggressive-paranoid behavior of patients with the syndrome of malignant narcissism facilitates the interpretation of this behavior in the transference. Suicidal behavior, for example, (that is, self-directed aggression), clearly represents a triumphant aggression toward the family or the therapist, or a triumphant “dismissal” of a world that does not conform to the patient’s expectations; parasuicidal, self-mutilating behavior may indicate the patient’s triumph over all those others who are afraid of pain, lesions, or bodily destruction.

FUTURE CONSIDERATIONS

We may summarize briefly the major negative prognostic features that emerge in this overall category of “almost untreatable” narcissistic patients as including the following: secondary gain of illness, including social parasitism; severe antisocial behavior; severity of primitive self-directed aggression; drug and alcohol abuse as chronic treatment problems; pervasive arrogance; general intolerance of a dependent object relation, and the most severe type of negative therapeutic reaction. The evaluation of these prognostic features is facilitated by a careful and detailed initial evaluation of the patient.

For example, regarding the nature of antisocial behavior, it is important to elu-

cidate the extent to which it corresponds to simple, isolated antisocial behavior in a narcissistic personality disorder without other major negative prognostic implications; or, to what extent it corresponds to severe, chronic, passive parasitic behavior that augments the secondary gain of illness; or finally, and most importantly, if we are facing an antisocial personality proper, either of the passive parasitic or the aggressive type.

At times, antisocial behavior may be strictly limited to intimate relationships, where it expresses aggression and revengefulness, particularly when accompanied by significant paranoid features. This may be important when, in the transference, it is directed at the therapist, because it may create such a high risk for the therapist that treatment under such circumstances might not be wise to attempt. This includes patients whose aggressive, revengeful acting out takes the form of litigious behavior against therapists, initiating a law suit against a first therapist while idealizing a second one who is "recruited" into a treatment for the damage done by the first one, in turn to be involved with a law suit initiated by the patient while he transfers to a third therapist for help, and so on. It may be wise not to accept a patient of this kind for intensive psychotherapeutic treatment while legal procedures related to the involvement with another therapeutic situation is still going on.

It is extremely important to differentiate suicidal behavior that corresponds to the authentic severity of a depression from suicidal behavior "as a way of life," not linked to depression, and typical for the borderline personality disorder as well as for the narcissistic personality disorder.⁶ Here, the differential nature of the suicidal attempts referred to before may be extremely helpful to diagnose the patient's case.

The elimination or reduction of secondary gain of illness is one of the most

important and often difficult aspects of the treatment, particularly in setting up the initial treatment contract and a viable treatment frame. The parameters of the treatment contract provide the assurance that the agreed-upon treatment frame will protect both parties (and the therapist's belongings and life situation) from patients' acting out that may evolve in the course of the treatment. In the course of the psychoanalytic psychotherapy of all patients with borderline personality organization, the emergence of severe regression in the transference is practically unavoidable, and frequently takes the form of efforts to challenge and break the therapeutic frame. In any such challenge, the therapist's physical, psychological, professional, and legal safety takes precedence over the safety of the patient. This would seem obvious or trivial, if it were not that so often therapists are seduced into a treatment situation in which their safety is at risk. Concrete conditions, relevant to each individual case, which clearly would indicate discontinuation of the treatment if not fulfilled, must be spelled out, and, if necessary, reiterated as part of the treatment arrangements, and then, as mentioned before, immediately interpreted regarding their transference implications.

Summarizing the indications for differential treatment approaches, for the mildest cases of narcissistic psychopathology a focused psychoanalytic psychotherapeutic approach or even a focal supportive psychotherapy may be the treatment of choice, and only if the severity of the corresponding character pathology warrants it, standard psychoanalysis. Standard psychoanalysis would be the treatment approach for the second or intermediate level of severity, and possibly for some cases of the severe spectrum of narcissistic patients functioning on an overt borderline level who, for individual reason, may make such a treatment possible. For most cases of

narcissistic pathology functioning on an overt borderline level or with severe antisocial pathology, the specialized psychoanalytic psychotherapy that we have developed at the Weill Cornell Medical College, namely, Transference Focused Psychotherapy (TFP) is recommended as the treatment of choice.¹ When individualized preconditions for treatment cannot be met in the initial contract setting,¹⁵ a cognitive behavioral or a supportive psychotherapeutic approach may be the treatment of choice.

In general, a supportive psychotherapeutic modality based upon psychoanalytic principles is indicated for cases where the patient's need for "self-curing" is so intense that any dependency is precluded, and obtaining active counseling and advice in a supportive relationship may be much more acceptable to the patient.¹⁶ When severe secondary gain cannot be overcome, and the patient's prognosis, therefore, would be severely limited with an analytic approach, a supportive psychotherapy focused on the amelioration of predominant symptoms and behavioral manifestations may be helpful. In cases with severe antisocial features that require ongoing information from outside sources and social control, technical neutrality may be too affected to carry out an analytic approach, and a supportive one would appear preferable.

For patients who, as a consequence of their long-standing illness, already have suffered such severe regression into social incompetence, all their "bridges burned" behind them, making a realistic adaptation to life much more difficult, a supportive psychotherapeutic approach may be preferable to a psychoanalytic modality of treatment. The latter one would have to face them with extremely painful recognition of having destroyed much of their lives: here the subtle and empathic judgment of the therapist regarding what the patient may be able to tolerate becomes very important.

REFERENCES

1. Levy KN, Meehan KB, Weber M, Reynoso J, Clarkin JF. Attachment patterns in borderline personality disorder: predictive and prescriptive psychotherapy implications. *Psychopathology*. 2005;38(2):64-74.
2. Kernberg O. Pathological narcissism and narcissistic personality disorders: theoretical background and diagnostic classification. In: *Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications*. Ronningstam EF, ed. Washington, DC: American Psychoanalytic Press; 1997:29-51.
3. Koenigsberg HW, Kernberg, OF, Stone MH, Appelbaum AH, Yeomans FE, Diamond D. *Borderline Patients: Extending the Limits of Treatability*. New York, NY: Basic Books; 2000.
4. Kernberg O. Technical aspects in the psychoanalytic treatment of narcissistic personalities. In: *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven, CT: Yale University Press; 1984:197-209.
5. Rosenfeld H. *Impasse and Interpretation: Therapeutic and Anti-Therapeutic Factors in the Psychoanalytic Treatment of Psychotic, Borderline and Neurotic Patients*. London, England: Tavistock Publications; 1987.
6. Kernberg OF. The suicidal risk in severe personality disorders: Differential diagnosis and treatment. *J Pers Disord*. 2001;15(3):195-208.
7. Kernberg O. Psychopathic, paranoid, and depressive transferences. *Int J Psychoanal*. 1992;73(Pt 1):13-28.
8. Bion WR. *Second Thoughts: Selected Papers on Psychoanalysis*. New York, NY: Basic Books; 1967
9. Spillius EB, ed. Melanie Klein Today: *Developments in Theory and Practice*. Vols. 1 and 2. London, England: Routledge; 1988
10. Spillius EB, Feldman M, eds. *Psychic Equilibrium and Psychic Change: Selected Papers of Betty Joseph*. London, England: Tavistock/Routledge; 1989
11. Steiner J. *Psychic Retreats*. London, England: Routledge; 1993.
12. Hinshelwood RD. *Clinical Klein*. London, England: Free Association Books; 1994.
13. Stone MH. *The Fate of Borderline Patients*. New York, NY: Guilford Press; 1990.
14. Green A. *On Private Madness*. Madison, CT: International Universities Press; 1993
15. Clarkin J, Yeomans F, Kernberg O. *Psychotherapy for Borderline Personality*. New York, NY: Wiley; 1989.
16. Rockland LH. *Supportive Psychotherapy for Borderline Patients: A Psychodynamic Approach*. New York, NY: Guilford Press; 1992.