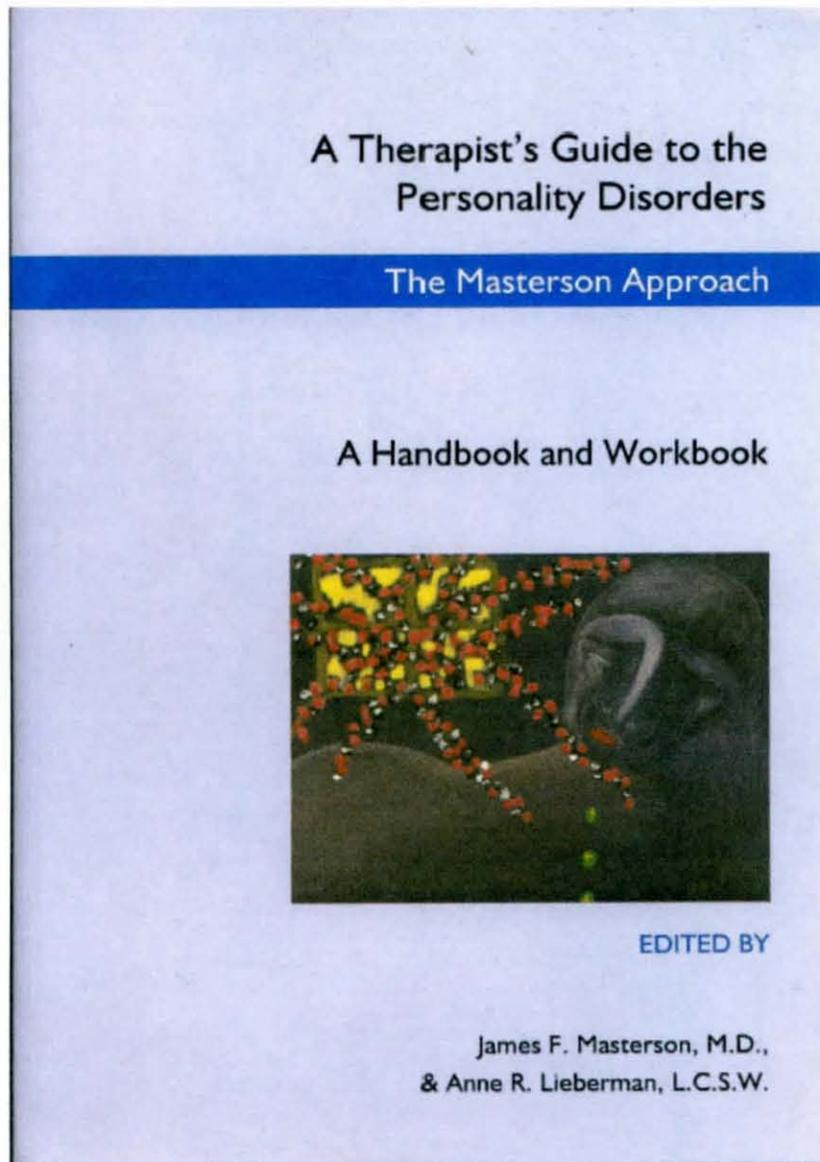


Masterson 2004

Masterson, J.F, Lieberman, A.R. (2004) A therapist's guide to the personality disorders



Masterson 2004, s.24

The term **object relations** refers to the internal representations of **self** and others with associated affects, and how these structures then influence relationships with one's self and with others. **Because of failures in development**, a significant difference between people with **personality disorders** and those without them is that people with personality disorders do not have whole **object relations**. That is, their **internal representations** of themselves and others are **split** into two part-units. Each part-unit has a very extreme, unrealistic, and one-sided view of the self (the part **self-representation**) and a very extreme, unrealistic, one-sided view of the other person (the **part objectrepresentation**).

Masterson 2004, s.26

NARCISSISTIC PERSONALITY DISORDER DIAGNOSIS CRITERIA DSM-IV

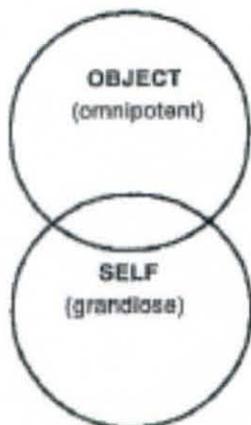
A pervasive pattern of **grandiosity** (in **fantasy** or behavior), need for **admiration**, and lack of **empathy**, beginning in **early adulthood** and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3. believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. requires excessive admiration
5. has a sense of **entitlement**, i.e., unreasonable **expectations** or especially favorable treatment or automatic compliance with his or her expectations
6. is **interpersonally exploitative**, i.e., takes **advantage of others** to achieve his or her own ends
7. **lacks empathy**: is unwilling to recognize or identify with the **feelings** and needs of others
8. is often **envious** of others or believes that others are envious of him or her

9. shows **arrogant**, haughty behaviors or attitudes

SPLIT OBJECT RELATIONS UNIT OF THE NARCISSISTIC PERSONALITY DISORDER

Defensive Fused Part-Unit

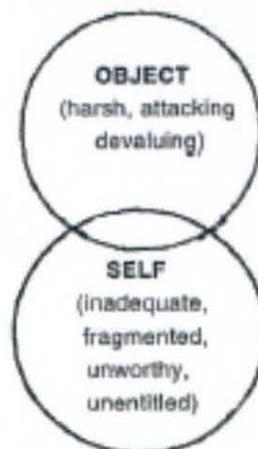


PATOLOGISK EGO / FALSK SELV

Linking Affect

being unique, special, great, admired, adored, perfect, entitled

Aggressive Fused Part-Unit



VIRKELIGHEIT'S EGO / SELV(ET)

Linking Affect

abandonment depression

SPLITTING

Ego Functions — poor reality perception; impulse control; frustration tolerance; ego boundaries.

Ego Defense Mechanism — splitting; avoidance; denial; acting out; clinging; projection; projective identification.

Masterson 2004, s.28

Another reason why individuals with **personality disorders** have difficulty behaving in an **adaptive** and **realistic** way is that the **ego is split** into two parts: **the reality ego** and the **pathological ego**. This split is a result of an **interruption in development**, and is in accord with Freud's belief that, normally, the reality ego gradually develops from the **pleasure ego**. This development occurs only partially in the patient with a personality

disorder, so that part of the **ego** continues to function in response to the **pleasure principle**. This part of the ego is called the **pathological ego**.

The pathological ego strives to avoid the **painful affects** of the **abandonment depression**. It supports the **false self** in denying reality and acting out instead of facing painful conflicts and activating the **real self**.

The Difference Between **Neurosis** and **Personality Disorder**.

So many different things have been written about **personality disorders** that sometimes "personality disorder" seems to be simply a new term for what used to be called "neurosis." However, when one looks at the situation through the lens of **intrapsychic structure**, it becomes very clear.

Individuals who have personality disorders have a split

Masterson 2004, s.29

intrapsychic structure; those with a neurosis do not. The major problems for those with a neurosis develop after they already have successfully achieved whole **object relations**. As the capacity for whole object relations is a **developmental achievement** that usually occurs around the end of the first three years of life and continues to be consolidated throughout adolescence, this means that the problems we label "personality disorders" began before age 3 and interfered with the normal consolidation of whole object relations (Mahler, Pine, & Bergman, 1975).

Diagnosis by **Intrapsychic Structure**.

Diagnosing a **Disorder of the Self** is most effectively accomplished by mapping out the patient's intrapsychic structure) as opposed to looking only at behavior or symptoms (as the **DSM-IV** does, for example). People may **behave similarly** or have **similar symptoms**, but still respond optimally to very different **therapeutic approaches**.

Masterson 2004, s.31

The Abandonment Depression

Those with Disorders of the Self remain largely unaware of how much they are **generalizing** from past experiences with their parents. They have developed a defensive system that is designed to protect them from experiencing the **painful feelings** associated with their **childhoods** and with the **lack of support** that they experienced for their developing real selves. These underlying painful feelings make up the affects of the abandonment depression. The abandonment depression includes such difficult and painful feelings as **suicidal depression, homicidal rage, panic, shame, guilt, hopelessness, helplessness, loneliness, and emptiness.**

Masterson 2004, s.42

The attributes delineated by the **DSM's** description of the **Narcissistic Disorder** are **pathological** in an adult, but quite **appropriate** to a newly mobile **toddler** engaged in what one developmental theorist called "a love affair with the world." Full of a sense of just-won power, able to stand on his or her own two feet and explore a universe alive with sound and color and smell, the unquenchable delight and sense of grandiosity of this young toddler stand in sharp contrast to the **depression** and **anxiety** of the older, "terrible-two-ish" "rapprochement" child engaged in the work of **separation-individuation**. This difference is directly traceable to the fact that the younger "practicing" child is still in a state of **intrapsychic fusion** with a perceivedly **omnipotent** maternal object.

Masterson 2004, s.43

Where the **mother's pathology** is such that she requires the child to resonate to her own narcissistic **projections**, **mirroring** will be **unempathic** and **defective**, leading to the preservation of **unmodulated grandiosity** as a way of defending the underlying, unsupported empty and **fragmented real self.**

This **libidinal unit of attachment** is separated by the **splitting defense** from the aggressive unit, which is composed of a part self-representation of being

humiliated, attacked, fragmented, and empty, fused with a part **object-representation** that is harsh, attacking, critical, and punitive. The linking affect of this empty/ aggressive unit is the **abandonment depression**.

However, whereas the **Borderline patient's** abandonment depression is triggered by **separation stress** or attempts at individuating **self-activation**, the Narcissistic patient's abandonment depression is precipitated either by the pursuit of **real self** as opposed to **narcissistic goals**, or by the sense of the **object's failure** to provide **narcissistic supplies** in the form of **idealizable omnipotence** or **perfect mirroring**. The defensive response to **narcissistic injury** and its consequences - **abandonment depression, narcissistic rage, and fragmentation** - will be an attempt to reactivate the **grandiose/omnipotent** unit by avoiding, denying, or devaluing the offending **object**.

The **Closet Narcissistic Disorder** is so named because, unlike the **Exhibitionistic Narcissistic personality**, the Closet Narcissistic patient's goes underground. For whereas the Exhibitionistic Narcissistic patient's **false self** is structured around the need to obtain **maternal mirroring** by continuously living up to the **mother's idealizing projections**, the individual with a **Closet Narcissistic Disorder** must continuously avoid the **mother's hostility, envy, and attack** by mirroring the mother and denying his or her

Masterson 2004, s.44

own **grandiose wishes**. **Narcissistic supplies** are then derived by basking in the glow of the idealized other's reflected glory.

However, underlying the self-effacing [selv-utslettelse] façade of the **Closet Narcissistic Disorder** lies the pool of **infantile grandiosity** that could not be made manifest, and was, therefore, never modulated. So, despite their very different outward presentations, the Exhibitionistic and Closet Narcissistic Disorders are but two sides of the same structural coin.

Masterson 2004, s.45

The pervasive need to defend against **internalized persecutory objects** leads to reliance on **rigid pathological defenses** that serve the purpose of **extruding and denying intolerable feeling**. The ability to sustain activity in the **external world** that ensures the more successful **Narcissistic individual** some measure of **supplies** is, in these less capable patients, limited or damaged, as the observing ego and tolerance of delay or disappointment are easily breached, to be replaced by **poor impulse control** and a failure to tolerate and master **anxiety**.

Instead, the intervention most suited to the **intrapsychic world** of the **Narcissistic patient** consists of what the Masterson Approach defines as a **Mirroring Interpretation of Narcissistic Vulnerability** that addresses the pain of the patient's real self in response to situations of **narcissistic injury**, and the defense used to ward off that pain.

Masterson 2004, s.73

THE NARCISSISTIC PERSONALITY DISORDER
Anne R. Lieberman, L.C.S. W.

A certain amount of **narcissism** is a necessary component of a **healthy personality**

Narcissism can be described as the **libidinal investment** in the **self**. **Normal narcissism** is necessary to regulate **self-esteem** and to pursue interests and **ambitions**. It is **reality based**; encompasses **self-satisfaction** experienced as **self-esteem, confidence**, and a general sense of well-being; and includes appropriate concern for others. Narcissism moves to the **pathological** when it becomes **self-centered, self-involved**, lacking in **empathy**.

This structure becomes pathological when it is **fixed and chronic**; repeats itself over and over, independent of the external environment; is based on **fantasy**; and defends against **affect**, rather than dealing with reality. It has strengths and weaknesses, which serve both adaptive and **maladaptive purposes**. Originally, it was not necessarily pathological; rather, it was the child's response to **developmental issues**. At one time, the **defenses** served a purpose. The problem is that they became fixed and **rigid**. In the

Narcissistic Personality Disorder, the intrapsychic structure of the patient provides a sense of **specialness** and **uniqueness** by either **identification with** or idealization of the object in order to ward off underlying feelings of **humiliation, shame, and fragmentation**.

Masterson 2004, s.74

They seek treatment, as do all patients with a **Disorder of the Self**, to feel better, not necessarily to get better.

... has **difficulty tolerating** differences of opinion.

... he repeatedly **loses jobs** because he has difficulty with **authority** and with acknowledging the opinions of others.

He can be **charming** and **funny**; he can also be **controlling** and **critical**.

... lying and secretiveness,

He did not understand why his wife was so angry or his colleagues and bosses so **intolerant** and impossible, ...

Masterson 2004, s.75

These two people do not sound alike. One appears invested in himself, and the other in the object. Yet, if we **scratch the surface** and look at the **intrapsychic structures**, we see a very different picture.

I. DESCRIPTION

The **Grandiose** or **Exhibitionistic Narcissistic Disorder**: We are all familiar with the picture of grandiosity. This is Harry. This is the individual with a façade of **self-assurance, self-confidence, and self-preoccupation**, who **constantly pursues admiration**. Perfectionistic in striving for **money, power, and fame**, he shows an **extreme sense of entitlement**, grows enraged

when **criticized**, and lacks **empathy** and concern for others in spite of pursuing them to obtain their **admiration and approval**.

The surface adaptation and **lack of anxiety** and **depression** exhibited by many patients with an Exhibitionistic Narcissistic Disorder can be misleading; they often look pretty good and on the outside appear to be functioning well. It is only when something in their world breaks down, often in their jobs or their families, that we see what lies beneath the façade. The underlying feelings include **intense envy**, **rage**, feelings of **worthlessness** and **rejection**, and a pervasive sense of **impotence** and **inadequacy**.

The Closet Narcissistic Disorder: The person with a Closet Narcissistic Disorder can be **deceiving**. He or she does not display overtly exhibitionistic behavior, and may even present as **humble**, **anxious**, **inhibited**, or **shy**. He or she may often first appear to be a person with a **Borderline Personality Disorder** in his or her focus on the **object**. This is so because the major **emotional investment** of the individual with a Closet Narcissistic Disorder is in the omnipotent other rather than in the self. The other is **idealized** and the patient's grandiosity is gratified. The patient then "basks in the glow" of the object. These individuals do not have the capacity consistently to maintain the continuity of **defense** of the **Grandiose Narcissistic patient**, and are more prone to experiencing **envy and self-esteem impairment**. They are also more likely to be **depressed**. Kathy is a good example of a patient with a Closet Narcissistic Disorder. She, as is frequently the case, first appeared to have a more Borderline personality organization. It was only upon examination of her **underlying intrapsychic structure** and her response to intervention that the similarities with the more overtly Exhibitionist Narcissistic personality became apparent.

The **Devaluing Narcissistic Disorder:** Most patients with a Narcissistic Disorder of

Masterson 2004, s.76

the Self will fall into the above two categories, activating a **grandiose self** or **identifying with an omnipotent other**. However, a smaller group encompasses patients who are different, either **projecting** the underlying

impaired self onto the other and then acting out the role of the **harsh attacking object** by **devaluing** anyone in their path, or by projecting the harsh object and taking on the role of the impaired self. This is the patient who will find fault with everything the therapist does, who is always expecting, and finding, **narcissistic injury**.

II. DIFFERENTIAL DIAGNOSIS

To arrive at a **differential diagnosis**, seven factors must be considered (Masterson & Klein, 1989, p. 9):

1. The presenting picture of the **false, defensive self**.
2. A review of current **ego/self functions** and impairments.
3. Developmental history.
4. Medical history.
5. Family history.
6. An assessment of intrapsychic structures.
7. The nature of the therapeutic relationship and response to interventions.

Once both **psychosis** and **neurosis** have been ruled out, it is necessary to differentiate among **the Disorders of the Self**. The style of **defense** in the person with a **Narcissistic Personality Disorder** differs from that of a person with a **Borderline Personality Disorder**, where the self- and **object-representations** are separate and **split** into two alternating part-units. The **Narcissistic patient's self-** and object-representations are fused rather than separate. The Borderline patient's projections of the rewarding and **withdrawing** units are not so strong that reality can be totally denied, devalued, or avoided.

The **rage** has a quality of **coldness** and lacks the relatedness of that of the Borderline patient. **The themes of power, perfection, and envy**, so prominent in the patient with a **Narcissistic Personality Disorder**, are **minimal in the Borderline patient**, whose themes tend to be **depression and anger** at the loss of wished-for supplies. **The Narcissistic personality** fears **fragmentation of self**, whereas the Borderline personality fears loss of the object.



Masterson 2004, s.77

The patient with a **Narcissistic Personality Disorder** pursues **admiration, perfection, and mirroring**, whereas the primary goal of the **Schizoid patient** is safety.

Further, the Exhibitionistic and **Closet Narcissistic Disorders** can be differentiated from each other by the way in which the patient presents his or her **false self** as either **inflated** (grandiose) or **deflated** (closet), , that is, by whether the **primary focus** is on the **self** or on the **object**.

OPPBLAGT

FÜR PUMPE

III. DEVELOPMENTAL THEORY

One of the real problems with understanding the **Narcissistic Personality Disorder** is the seeming paradox that a very **primitive self/object-representation** is seen alongside what **appears to be** a high capacity for **ego functioning**.

Typically, the **Narcissistic patient**, particularly the higher-level one, will describe his or her childhood as good, with **idealization of the parents**. However, three basic histories emerge.

1. **Exhibitionistic**: Parents use the child as an extension of their own **grandiosity**. **Expectations are projected** onto the child, who feels **adored, admired, and loved in a way**, through this **projection**. **The mother** is always there to **promote the child**. The **real self** goes underground; the **child's grandiose self** is being **mirrored** and stays out. **Any appearance of the real self** is met with **scorn, humiliation, derision, shame, cold**

Masterson 2004, s.78

withdrawal, disapproval. In response, the idealized child will bring out parts of the self that connect with the mother, developing into a fused, **grandiose, omnipotent unit**. The child **feels loved**, but, in fact, **was used**. Upon closer examination, the **mother appears** to have been **cold and exploitative**, unable to **acknowledge, confirm, or support her child's real self**, and instead, **treats the child** as an **extension** of her own frustrated needs. The **child's preoccupation** with maintaining the **mother's idealization**

preserves the **grandiose self** and helps to **avoid awareness** of the **real self** and of the **mother's empathic failures** and **depersonalization of her child**.

... described her as a **dependent, fearful, symbiotic, but not nurturing, woman** who **lived for her son** and made him the **center of her life**.

2. Closet: In the second case, there are two possible scenarios. One, the child comes up against subtle or not-so-subtle scorn, derision, and **humiliation** for expressing **her real self**. She has memories of being attacked, **devalued**, and **disparaged as a child**. She learned not to get rid of the **grandiosity**, but to put it into **hiding**. She **connected with the parent** by **downplaying her self**, by **excessive modesty**. She is constantly **scanning the environment** for evidence of the **hostile depreciation** by the other. Or, two, the **parent communicates** to the child that **if the child reveres the parent**, the child will be **loved, adored, and tended to**. In either case, the probable outcome is a

Closet Narcissistic Personality Disorder, where **the child idealizes the parent** and **effaces the self**. This person is more prone to **narcissistic vulnerability and injury**, and is more aware of the **impaired self** (Fischer, in Masterson & Klein, 1989, p. 70), and can often first appear to have a **Borderline personality structure**.

Masterson 2004, s.79

She described her **father as ineffectual**, sweet, often **depressed, never very successful**, and somewhat **lost**. Her mother worked on an assembly line, but would go to work every day dressed in a suit and white gloves. She was experienced as a **critical, narcissistic woman** whose constantly repeated message to Kathy had been to protect her from any information or **emotion** that might upset her. Kathy said that her **mother loved her best when she was "seen and not heard,"** but was a good student whose **performance** reflected well on her parents. She stated that she forever **falls short** of her **mother's (and her own) need for perfection**, and repeatedly expressed her sense of her own inadequacy about her ability to function in an **autonomous position**. She has a **paralyzing fear** of being a **disappointment** in her own eyes and those of the other, and demonstrated an inability to observe and take credit for her many accomplishments, saying, "If I can't see myself **reflected positively** in the eyes of the other person, I have no **self**."

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3. **Devaluing**: Derision moves into intimidation, violence, violation, **abuse**, a consistent threat against expressing real or **grandiose needs**. This kind of treatment can result in a low-level **Devaluing Narcissistic Disorder**. There is no grandiosity of the **self** or **idealization of the other**, but the child lives in a **state of siege**, with **paranoid, Schizoid defenses**.

the **DSM-IV**, which presents a **purely descriptive, external portrayal of the Narcissistic Personality Disorder**, the Masterson Approach utilizes an understanding of the internal **intrapsychic structure of the patient**.

The person with a **Narcissistic personality organization** has a **fused object relations unit** (see chart on page 80), which differs markedly from the **split object relations unit** of the **Borderline patient**. In the **Narcissistic Personality Disorder**, this part of the **intrapsychic structure** has been designated the "**grandiose self-omnipotent other**." The **outward, defensive unit** is that of a **grandiose self-object**, which is **superior and elite**, with an affect of being **perfect, special, or unique**. The **omnipotent object is perfect and powerful, and necessary for idealization and mirroring**.

Masterson 2004, s.80

The **Closet Narcissistic patient** projects the omnipotent object, and **idealizes the perfection of the object**, which he or she **expects to share**, that is, **the patient basks [sole seg] in the glow of the object**.

The linking affect in both cases is one of being **unique, great, wonderful, special, promising, adored, perfect, entitled**.

What is well hidden beneath this **grandiose self-omnipotent object structure** is the **aggressive or empty object relations unit**, which is the other **fused self/objectrepresentation**. It consists of an **object that is harsh, punitive, and attacking** and a **selfrepresentation that is humiliated, shamed, and empty**, linked by the affects of the **abandonment depression**, which are different from those of the **Borderline individual**. With the **Narcissistic personality**, the **abandonment depression** is experienced as **shame, humiliation, narcissistic injury, a colder**

sense of outrage, and a lack of relatedness. The resulting **extreme sensitivity to feeling criticized or attacked** forces the

Masterson 2004, s.81

therapist to rely on therapeutic interventions other than confrontation, primarily **mirroring** interpretations of **narcissistic vulnerability** (Fischer, in Masterson & Klein, 1995, p. 70).

Because the affects of the **abandonment depression** are so devastating, they are immediately defended against by **externalizing the depression and projecting** its object-representation as causing the depression. In other words, the **problem is out there**; it is what **others are doing** to the patient that is so **upsetting**. The patient then proceeds to **avoid, deny, and/or devalue the offending other**, thereby **restoring the balance** of his or her **narcissistic equilibrium** and **avoiding the experience of depression**.

The relatively free access to **aggression** enables the person with a **Narcissistic Personality Disorder** either **aggressively** to coerce [tvinge] the **environment** into resonating with his or her **narcissistic projections**, or, if this fails, to **deal with that failure by projection, avoidance, denial, and devaluation** (Masterson, 1981, p. 16). In order to protect this **illusion of omnipotence and invulnerability**, the patient will **deny, devalue, dismiss, withdraw** from, or **rationalize** any stimuli that challenge this **omnipotence and invulnerability**.

Therefore, in order to keep his **grandiosity** intact and the underlying **depression** at bay, Harry's explanations for his lost jobs and marital problems were that his superiors were basically jerks who did not appreciate his suggestions and ideas, while his wife simply misunderstood him, could not see the wisdom of his choices, and was unsupportive.

The **intrapsychic structure** of the child is formed in response to **developmental stressors** that result from a combination of nature, nurture, and fate. Nature refers to the **genetic endowment** of the infant, whereas **nurture** reflects the maternal capacity to support the **emerging self**.

When the **sense of self** of the **Narcissistic patient** has been so severely **injured** because of ruptures in any or all of these, a child will:

1. **Dismiss the real self**, and try to recapture the **narcissistic relationship** by becoming **grandiose**.

2. Push the **real self** underground, **idealize the object**, and try to comply (Closet).

Masterson 2004, s.82

3. Or **feel under siege**, in danger of **disintegration** or **fragmentation** if the object was

so **narcissistically injurious**. The child will **give up on being mirrored by**, or **idealizing, the mother**. There is a strong development of the **aggressive-empty unit** that is **projected externally**, in order to **protect the self** against the perception that the other is **harsh and attacking** (Devaluing).

The resulting impairments in ego functioning will include **poor reality testing, poor impulse control, poor frustration tolerance, poor ego boundaries**, and the use of **aggression to manipulate the external world** to get **narcissistic supplies**. The **ego defense mechanisms** that will be most prominent are **splitting, avoidance, denial, acting out, clinging, projection, projective identification, idealization, externalization, devaluation, and omnipotence**.

For the person with a **Narcissistic Personality Disorder**, **self-esteem** and **selfworth** are externally derived. These patients **tend to do better earlier in life than later**, when **losses and demands for intimacy** and to give are much stronger. **Aging is the ultimate narcissistic wound**.

V. TREATMENT

The **Narcissistic patient** enters treatment with a focus on **defense** rather than on internal conflict and painful affect.

The main **therapeutic challenge** when working with the **Narcissistic patient** becomes finding a way to enter the patient's system to effect therapeutic change without precipitating a **defensive reaction**.

With the **Borderline patient**, the focus is on confrontation of defense. Confrontation of the **Narcissistic patient**, however, will be **experienced as an attack on the grandiose self**, resulting in a real sense of **narcissistic injury** and necessitating a **tightening of defense**.

Narcissistic patients will **avoid pain** by **avoiding exposure of their real selves**, seeking instead something that feels better, either fusion

Masterson 2004, s.83

with or **idealization of the object**.

In the case of the **Closet Narcissistic patient**, the focus should be on the **failures in the idealized object**.

The **mirroring interpretation** of **narcissistic vulnerability** consists of three parts, which can be remembered by the phrase "pain, self, defense." Broken down, each component of the intervention is as follows:

1. **PAIN**: Identify and acknowledge the **painful affect** the **patient's self** is feeling.

This is the mirror that demonstrates to the patient that you **understand and empathize** with what he or she is expressing, and makes it possible for you then to add:

2. **SELF**: Emphasize the impact on the **patient's self** in such a way as to indicate

your understanding of the patient's experience.

3. **DEFENSE**: identify and address the **defense or resistance**, which can then be

Masterson 2004, s.84

is **then** tied to the first part by observing how it **protects) defends) calms, and soothes** the patient from the experience of the **painful affect**. It is important

to point out the **function of the defense** with great care in order to avoid precipitating a **narcissistic injury**. **Keep in mind that the patient's action arose from a need to maintain his or her self-esteem or sense of self-cohesion [sammenheng]"** .



Should they touch on a subject that brings up **painful affect**, they will change the topic to one that moves them away from feeling by **reinstating the defense**.

When an intervention abruptly disrupts the sense of merger, the patient will feel **narcissistically wounded, criticized, misunderstood, and badly treated**. In that case, the patient will often leave therapy prematurely and abruptly.

Masterson 2004, s.85

The Closet Narcissistic Disorder

Unlike the **Exhibitionistic patient**, the less obvious **Closet Narcissistic patient's** transference acting out will take the form of focusing on the object instead of on his or her own **painful feelings**. Often this type of defense can be mistaken for the **clinging** of the **Borderline Personality Disorder**, and can only be differentiated by understanding the function of the **defense**.



Understanding the patient's need for **idealization** made it much harder to buy into her **projections!**

Masterson 2004, s.86

"It's really difficult for you to talk about yourself (pain), which leaves you feeling **exposed and vulnerable** (self). To **protect yourself**, you try to get me talking, and then maybe we can stay away from that **painful stuff**" (defense).

"Being at that party was really so painful for you because so many of the people there seemed to have so much of what you'd like for yourself

(pain). When you're with them, all you can think about is **what you don't have**. Eventually, this causes you to feel terrible about yourself, as though there is something wrong with you (self). So, to soothe these feelings, you put the group down and tell yourself that they're not worth it, that you can find better friends (defense). The problem is that you can't seem to find a place for yourself."

The risk is that as soon as the patient experiences the therapist as of value, this will evoke **dependency** feelings that will lead the patient to **feeling envy, shame, humiliation**, which he or she will then try to **control** by moving away from treatment.

For a **Closet Narcissist**, the emphasis is on interpreting the patient's need to focus on the **object**.

Masterson 2004, s.87

Understanding the **Disorders of the Self Triad** is as crucial in working with patients with a **Narcissistic Personality Disorder** as it is with the other personality disorders. Briefly, what this means is that **self-activation leads to anxiety and abandonment depression**, which leads to **defense**

Typically, this takes the form of **reinflating the grandiose self**, or **remobilizing the omnipotent object**.

After repeated cycles through the triad, the patient gradually becomes more aware of his or her **real self** and how it differs from the **false, defensive self**.

Masterson 2004, s.88

Real intimacy is possible because the patient can experience others as separate individuals with their own separate centers of initiative, ... The basic goal of shorter-term treatment is to improve the patient's **adaptation to reality**.

Although once-a-week therapy is not enough to allow for a restructuring of the personality, it is enough for the patient to make significant gains in insight and functioning.

Many of these patients come to therapy **having no idea** why they so frequently **feel awful**.

Masterson 2004, s.79

Working with **Narcissistic patients** can arouse intense **countertransference** feelings in the therapist.

Masterson 2004, s.142

28. The **Closet Narcissistic Personality Disorder** can be differentiated from the **Exhibitionistic Narcissistic Personality Disorder** by:

- a. A fear of being **appropriated [lagt beslag på]** by the other or of **being alone** in the universe.
- b. A **projection** of the rewarding or withdrawing units.
- c. A **false self** that is **grandiose** or **deflated**, with primary focus on the **self** or on the **object**.
- d. The profession chosen by the patient.