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# Reaching the Covert, Fragile Side of Patients: The Case of Narcissistic Personality Disorder



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A multifaceted self allows selection of those sides that are most suited to a situation and an interpersonal context, thus improving adaptation. Patients suffering from personality disorders display a limited range of self-aspects, and their relationships are stereotyped and maladaptive. Another problem is that some of these sides scarcely reach consciousness and usually remain in the background. In the case of narcissistic personality disorder (NPD) the self-part that is fragile is unlikely to reach consciousness, so that people suffering from this disorder are impervious and detached. We present a case of a psychotherapist working with a woman suffering from NPD by facilitating the emergence of the fragile part of her self, hidden by angry and scornful characters. We demonstrate, moreover, how reaching such a self-part is associated with an improvement in the patient's interpersonal relationships outside the consulting room. © 2006 Wiley Periodicals, Inc. *J Clin Psychol: In Session* 63: 141–152, 2007.

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To adapt to a complex environment, brimming with problems of a varying nature, individuals need to adopt strategies consistent with the context. To care for a child requires feeling several emotions such as affection and tenderness—and behaving, for example, lovingly or severely according to circumstances. When courting a partner we instead display different self-facets and try to appear witty, seductive, full of fun, or physically pleasing. The list could continue; it is as long as that of the relationships society offers us.

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A long experimental psychology tradition attests that being able to call on multiple self-aspects and using the appropriate ones for each situation promote adaptation. They also protect from suffering, because any failure is localized and is not applied generally to all an individual's being. Linville's motto (1985), *Don't put all of your eggs in one cognitive basket*, sums up the concept.

The proposition is backed up by psychological research, even if not in a uniform manner, and by clinicians' observations: adopting multiple roles and experiencing a wide-spread range of affects make it easier to live in society. Patients who have personality disorders (PDs) are not, by definition (American Psychiatric Association, 2000), flexible vis-a-vis their context. The people they meet and the problems posed to them by life are continuously changing, but their behavioral style remains the same. Narcissists tend to feel the need for confirmation of their self-esteem by colleagues, partners, and friends, even if, at particular moments, it would be more beneficial if they were caring or cooperative or avoided showing themselves off. Paranoids feel constantly threatened and are unable to suppress their hostile, angry, and resentful reactions, even though it would be to their and others' advantage if they restrained them.

In this article, we describe and illustrate how our PD therapy, metacognitive interpersonal therapy (MIT; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007), is suited to dealing with the problems of restricted self-multiplicity, lack of access of self parts to reflective thinking, and lack of contact among different parts of the self.

According to our review of the literature and our clinical observations, there appears to be a specific kind of impoverishment of relationships in each PD, which is driven by a specific set of self- and other-schemas. Each PD also involves particular adaptation disorders (Dimaggio et al., 2007). One of the aims of MIT, which we describe in the following, is to identify the internal representations of relationships driving individuals to act in a rigid and stereotyped way and, slowly, modify them. This is no simple task.

PD patients, in fact, also use their dysfunctional schemas for constructing the therapists trying to treat them. The latter thus often find themselves in unpleasant situations. In some cases patients see them as hostile and attack them furiously, in others they despise or defy them, and so on. It is not the best atmosphere in which to work closely together for several years.

A clinician wishing to treat PDs needs to find the causes behind a problematical therapeutic relationship and avoid contributing to making its quality worse. It is, we believe, natural for therapists to react to the way in which patients treat them: if they feel challenged, they tend to want to show their worth and to win the competition; if they are despised, they feel useless and unwelcome or defend themselves; and if they are ignored, they tend in turn to lose interest in the relationship or desperately try to be acknowledged. Anyone dealing with PDs knows such inclinations well; they need to be overcome, to prevent any interruptions to treatment and ensure that it is successful (Clarkin, Yeomans, & Kernberg, 1999; Dimaggio et al., 2007). In PDs the pressures making a relationship negative depend mainly on the type of PD; however, the therapist's personality obviously has an important influence. In other words, all therapists faced with narcissists are likely to want to compete or to feel excluded or despised (Dimaggio, Fiore, Lysaker, et al., 2006), but each therapist has his/her own way of reacting. Some might recall being humiliated by their parents, to whom they still look for approval; others might cut themselves off because they cannot bear being ignored; and so on.

If their treatment is to be successful, therapists treating PDs need to make full use of their personal and technical resources. We have developed a model taking account of the complexities of treating such patients (Dimaggio et al., 2007).

## Metacognitive Interpersonal Therapy

The roots of MIT are constructivist (Kelly, 1955) and we have drawn inspiration in particular from authors who have noted how patients have a recognizable set of forms of experience, termed *states of mind* (Horowitz, 1987; see Ryle & Fawkes, this issue), some of which are sources of suffering. Patients also have difficulty in switching into pleasant states; for example, each time they relax, they immediately have guilt feelings. States of mind surface in line with trends in interpersonal relationships. A prime example might be a patient with avoidant disorder, who does not pass his university exams because he is sensitive to the criticisms of another he sees as contemptuous and humiliating. His performance on the exam is poor because his expectations make him freeze when faced with his professor/monster; alternatively he is so rapid and sure in his anticipation of the other's role that he does not even attempt the test.

With further inspiration from work on how to repair ruptures in alliances (Safran & Muran, 2000), we would suggest that the main steps a therapist should take to improve the relationship with a patient are the following: (1) identify the main relationship patterns both in patient narratives and between patient and therapist; (2) modulate one's own reactions by first identifying and then restraining one's negative action tendencies; (3) find conversational topics on which one is in tune with the patient. When therapists and patients are attuned, that is, when the latter feel that their therapist understands what they feel and think and is interested in what they are interested in, therapists should try; (4) to stimulate awareness of problematical schemas. This situation is first one in which patients' inner multiplicity is reawakened: they construct an observing self, which sees their inner world from a new vantage point (Semerari, Carcione, Dimaggio, Nicolò, & Procacci, 2004). In time, the therapist can then (5) draw any healthy parts, kept in the shadows and squashed by the self's problematical aspects, to the surface. When this process is successful, the self is truly enriched; patients widen their range of affects and ways of relating and use their new knowledge to tackle the world more flexibly and with less suffering.

The therapeutic relationship with patients who have PDs is problematical also because they are poor at acknowledging their psychological problems, understanding the causes of their emotions, seeing self-parts that do not usually inhabit them as their own, and understanding others' intentions in a sophisticated way. We call this set of skills *metacognition*, that is, the sets of skills that people use to reflect on their own thoughts, describe their emotions, understand the causes of their feelings and beliefs, differentiate fantasy from reality, read the minds of the others in a decentered way, and use this knowledge to adopt creative solutions in everyday life and master psychic suffering. Various works have shown how metacognition is lacking in PD patients (Semerari, Dimaggio, Nicolò, Procacci, & Carcione, in press). Patients who have poor metacognition are unable to perceive self-parts, such as a fragile one in need of help, or to realize that, behind the mask of hostility they ascribe to another, there is someone willing to help and capable of doing it. Finally, being deficient in reading others' minds and in knowing their own, they have difficulty in constructing a dialogue with their therapist, which would help them in negotiating treatment goals and the meanings emerging in conversation.

Improving metacognition is, therefore, the second fundamental aim of our therapy. We aim to promote metacognition both in the heart of the therapeutic relationship and, in the long term, in a patient's daily life. We try to render patients aware of the various facets of which they are composed and of the motivations driving them to act, and to make them construct others in a careful and sensitive, rather than egocentric and stereotyped, manner (Dimaggio et al., 2007).

In this article, we illustrate our therapy approach with Elena, a woman diagnosed with narcissistic personality disorder (NPD). Her self- and other-representations were impoverished and problematical, and she was lacking in metacognition. As a result, she was unable either to see her own fragility or to ask her therapist to help her.

### Case Illustration

#### *Presenting Problem*

Elena sought treatment 1 year before the psychotherapy described here, conducted by one of us (G.N.). She had earlier seen a psychoanalyst because she found it unbearable that she was taking orders at work from incompetent and incapable people. Her conflicts with authority had created a void around her: none of her colleagues had any relationship with her. She had abruptly terminated a love relationship because having sexual relations was, for her, like being raped. She was no longer attracted and was unable to reach an orgasm. She saw her partner as an "adversary." She had left her hometown after accusing her employer of defrauding a company that had given them some business. As a result, she had not been offered work in any other firm.

Elena suffered from a major depressive episode and from amenorrhea and asthenia. Her psychoanalysis ended after 8 months. Elena told how she had begun to trust the analyst and had finally declared that she frequently felt split into two people, with one deciding for the other. At this point, the psychoanalyst reportedly stated that Elena's case was too serious for her and that she would refer her to another colleague. The psychoanalyst might have been fearful because she believed the patient to have paranoid delusions. Elena accepted this decision, not least because she felt no longer in control of her life, but the psychoanalyst never replied to Elena's telephone calls. As a result of this probable abandonment Elena suffered insomnia, depression, and suicidal feelings. She consulted her general practitioner, who referred her to G.N.

During her first session, Elena suddenly remembered an appointment she had had with another practitioner before the psychoanalyst. Her memories of the interview were surprising. She had felt attuned with the therapist but decided not to continue with treatment because she had the (unfounded) impression that the therapist, from the same part of central Italy as she, knew her parents. She recalled the interview as being one of the most attuned moments in her life!

#### *Client Description*

Elena, 31 years old, was born in a small town in central Italy. Her father was a professional man and her mother an unemployed aristocrat. She had a brother 5 years older than she, a university lecturer. She had two degrees, in economics and physics, both first-class. She took pride in her academic qualifications. She had not had a partner for several years, and her previous relationships had always ended abruptly. There was no reported history of psychiatric or major physical illnesses in the family of origin.

#### *Case Formulation and Diagnosis*

In the first session Elena asked the new therapist whether he could treat patients who had serious conditions. She was formal and stiff. The therapist asked her for some life episodes to find out more about her. A dramatic situation emerged. Elena had received three warning letters from her employer for punching a colleague, who had not allowed her to

use the photocopier, when, in her opinion, it was urgent. Her anxiety about being dismissed was so intense that Eleana and the therapist met three times a week initially.

During her assessment an episode from her past emerged: at 16 Elena held a birthday party. None of the school companions she invited attended. Elena did not feel neglected, as one might think, but *despised* them. In fact, she was angry with herself for cutting a poor figure with her mother, in that the party was a flop, and was worried that the latter might reproach her for being poor in her choice of friends. She immediately remembered when she had been ill for almost a month at 21. Her mother refused to call a doctor, as she was afraid to disturb him; if she had called him without a serious reason, he would have had a poor opinion of the family. One month later Elena was hospitalized for meningitis. She told the therapist this with great satisfaction and a sense of revenge at having defeated her mother. She had been right: she really was ill!

The patient's reaction to the first therapist—the notion that the therapist knew her parents and her poor social functioning—made the current therapist suspect a psychosis. However, this possibility was excluded by her continued professional functioning and by preserved reality testing. The signals that it was a personality disorder (PD) were much more evident. Elena had already, during her adolescence, displayed: sensitiveness to embarrassment; a tendency to challenge others, to compete, and to react angrily; and an impulsiveness toward anyone blocking her. She was also unable to express feelings of weakness or fragility, or to ask for help. Her image of the other was, depending on the situation: a judge before whom she felt embarrassed, a stranger whom she was annoying, or someone incompetent and not worth considering. The themes in her reference ideas were also consistent with her life theme of fear of being controlled.

The final elements characteristic of a PD were her chaotic interpersonal relationships and her indecisiveness about her long-term goals, as demonstrated by her two degrees in completely different fields. The most likely disorders for a main diagnosis were narcissist (defiance, competitiveness, exhibitionism, lack of demonstrations of fragility and of need for help), paranoid (describing others as threatening, incompetent, ill intentioned, and controlling), and borderline (impulsiveness, vagueness about identity, instability in romantic relationships, and suicidal feelings).

The therapist's emotional reactions were decisive for determining the personality aspects on which to concentrate in the therapy. Despite his alarm at her suicidal feelings and fear that the patient might become psychotic, both typical of a reaction to a borderline patient, the therapist found he was unmoved. He did not see Elena as being fragile and needing help and did not feel motivated to give it. This is a typical narcissist-provoked reaction (Kohut, 1971). If Elena had principally had borderline disorder, the therapist would probably have felt stirred to do everything possible to treat her and would have felt strongly involved. At the same time, the therapist found he was often competing with her and fighting to make his own ideas prevail. A paranoid patient would probably not have provoked the same feelings and would, on the contrary, have made him be very cautious, weighing every word for fear that the patient, feeling hurt and humiliated, might counterattack. His diagnosis was therefore NPD with borderline and paranoid traits.

### *Course of Treatment*

The therapy proved immediately to be difficult and delicate. According to MIT (Dimaggio et al., 2007), one of the problematic aspects of a limited multiplicity of the self in PDs is the lack of healthy areas or self-parts with which a therapist can forge a solid alliance. In Elena's case, each time that a relationship became feasible and attuned, this emerging self-facet was submerged by pathological elements.

An example was her meeting with the first therapist: maximal attunement temporarily triggered a delirium! The therapist thus knew that he had limited room for maneuver. Attuning was risky; competing would in the end lead the relationship to break off; caretaking was not possible because Elena would not ask for help as she felt the other would ignore her (as her mother neglected her illness) or feel she was being too pressing (as her mother thought that calling the doctor might annoy him).

What should a therapist do in such cases? It is best to keep the risks to a minimum, that is, to enter the part of their relational world that patients master best. In Elena's case, the least dangerous part was competitiveness, provided it was limited to pretend play, without any challenges being direct or threatening her self-esteem. The reason was that when competing, Elena felt a strong sense of self-efficacy and could, from this safe position, build an idealized image of the therapist. In other words, Elena's self-multiplicity was restricted because the voice we describe as *superior, contemptuous*, and having *high self-efficacy* dominated in her discourse and backgrounded other parts of the self. As a result the therapist was forced to embody a similar character voice and to prevent both being put in a despised position and counterattacking. Kohut suggests (1971) that a therapist should partially accept this idealization. The therapy thus became an intellectual game between two well-educated people. They provoked each other but humor prevailed. The therapist constantly monitored his tendency to challenge and each time he felt hurt and driven to counterattack, he silently backed off.

During this competition regulation process, there was, in session 3, a key episode. Elena maintained she was driven more by passions than by reason: "The main decisions in my life have been gut ones!" She began to talk about Eisenberg's indeterminism principle and Schroedinger's equation. The therapist could not see how these might be related to her problems and confessed he did not know Schroedinger's equation! Elena was surprised, for her it was like not knowing the definition of God, which was very important in biology—a field a doctor ought to know well—too. The therapist (who, by the way, also had a first-class degree), admitted that a biology exam was the only one he had once failed. Elena's reply was almost incomprehensible: "cells have a certain form . . . there are the nucleus, the endoplasmatic reticulum and within this there is a world of extremely complex molecules . . . moving about as if in a Bach symphony . . . and if one thinks that each of these complex molecules, starting with DNA, is in turn a world of its own . . . a melody . . . God is who plays it." At this point the therapist felt disoriented and started to challenge some of her assertions, so that a competitive cycle was triggered. The therapist realized what was happening and backed off, by trying to restate his words in psychological terms and linking them to the question of her fear of dismissal:

THERAPIST (T): Good! Can you explain to me why you've told me all this?

PATIENT (P): No (*laughs*)! I mean yes. I can explain it! Because, instead of closing brackets, we've kept on making them longer!

T: We were talking about this person who wanted to fire you from . . .

P: Yes. but why did I somehow hit on Schroedinger's equation as the fundamental principle?

At this point Elena returned to speaking about her life and focused on her own experiences instead of talking theory. Shortly later in the same session the therapist asked her what she had felt during their dialogue:

T: When I told you I didn't know that equation, you were surprised. How come?

P: Yes! Because you're a doctor! And in fact you did know it . . . anyone with a science degree must know it! I thought how can it be? It's true that you're a doctor and

doctors study these things in their first year and that's all there is to it! I mean! I . . . I have the feeling that you're a good doctor and so I automatically think you must know the things that any doctor, physicist, scientist, geologist. . . .

T: Hmm . . . and if I don't know it?

P: So much the worse for you!

T: I mean: the fact that I'm a doctor . . .

P: . . . No, I don't consider you to be the fountain of truth. Don't worry!

T: Don't even think that!

P: (*Laughs*) I wouldn't dream of it!

Elena swings between idealization and devaluation but the atmosphere is ironic and she says she trusts the therapist. The latter felt he could continue to explore her emotions toward him. He noticed a facial expression that appeared significant and so, even if Elena did not admit to reacting to the event, he insisted. After various failed attempts he suggested some emotions she might have felt. With some difficulty this operation is successful:

T: I got the sensation that you were afraid!

P: No.

T: Sure?

P: Sure? No!

T: Didn't you feel threatened?

P: Not . . . threatened . . . but not afraid either! If I really must name a sensation, it was like that . . . a little emptiness, as it were! But not fear!

T: Emptiness?

P: Just a little!

At this point the therapist suggested that Elena had felt emptiness because she had seen him as being, on the one hand, imperfect and, on the other, incapable of total attunement. A new voice appeared, *empty* and *insecure*, the first sign of enrichment in Elena's discourse. Elena found the hypothesis plausible, stopped being competitive, and explored the new voice:

T: Are you aware that this empty feeling . . . you would notice it at the time you couldn't manage to fulfill a condition (*the condition being total attunement with a perfect other*)

P: Ah . . . exactly!

T: This is a hypothesis of mine.

P: . . . It's probably true! I mean, I say it for the record.

T: My sensation is that, if I don't know an equation, you run the risk of finding yourself exposed to empty parts.

P: But this is probably correct. . . . I'm telling you this for the record. . . . I reckon that's how it is! . . . I've just thought that it's rare for me to be afraid.

Elena was getting ever better at identifying her own feelings, with a clear improvement in her metacognition, in particular as regards self-reflexivity. She was no longer talking abstractly:

T: Do you not know if it's a feeling of unreality?

P: No, it's a feeling of . . . emptiness. It's solitude, in fact.

We believe that the surfacing of the empty and lonely part of the self depended on the fact that the therapist, once he had extracted himself from the competitive situation, first demonstrated his own failings and then explored Elena's sentiments toward him. The self-part, which feels alone and empty if the other is imperfect, emerges overtly for the first time in psychotherapy and Elena affirms that it is new.

After a long dialogue involving, at various times, interpersonal defiance, story telling and humor, the two of them slowly realized that if Elena ascribed a defect to herself or others, she despised them. This is typical of narcissists, who do not accept failings in anyone. The therapist knew he was held in esteem by Elena and was the first to show his weak side, thereby allowing her to do the same.

In subsequent sessions the therapist insisted that she stereotypically described others as inept or ill intentioned and that this was an obstacle to attentive relationships. He suggested that this was particularly deeply rooted in her relationship with her mother. In fact, when Elena was suffering, her mother was both critical and incapable of caring for her, as witnessed by the meningitis episode. After enduring maltreatment, arrogance, and criticism, Elena had learned to react with anger and to seek self-sufficiency. This life theme surfaced repeatedly during the first months of the therapy, albeit punctuated with new elements.

In session 4 Elena arrived at a new point of view on her mother. Her previous therapist had compelled her to understand and forgive her mother, with the sole result that Elena became angry and depressed. The present therapist realized that it was like asking her to vindicate an executioner without understanding her suffering. He put himself in her place and validated her negative emotions. The result was as follows:

P: I've had an epiphany. I was in the bathroom. . . . I have to get along somehow—also because to pay you too [the therapist] I have to save . . . so I do my own cleaning . . . I've learned how to . . .

T: Excuse me, you mean you go cleaning toilets?

P: No. Just mine.

T: Ah, yours!

P: . . . (*Laughs*) I'm not yet so . . .

T: You joke, but it's one of the most noble things you can do.

P: I learned to wash the dishes at about 6. I've always done my own . . . priding myself on the fact that I've been so efficient . . . I've learned with experience that someone who cleans each time . . . especially in the bathroom, with each little drop of water . . . saves work since, I don't know, I'd done the bathroom, there were a few drops of water, and I was cleaning, I was on my knees with the floor cloth and, while I cleaned, I thought that, when I was small, my mother used to say to me, so many times, when I walked into the bathroom: "Don't go treading" and I'd say: "How can she be so spiteful?" . . . because I thought: "Oh my goodness, if I step on this, then it'll spread everywhere. I'm wearing shoes; there's sure to be a stain and then I'll be three hours at it." And while I thought of my mother saying this, I had the clearest sensation for the first time that I was justifying her . . . the sensation of someone with a deep-seated fear . . . like saying that in cleaning with the floor cloth there was not only her activity, but also the frontiers of her world. So that her spitefulness was not so much spite toward me as a reinforcement of a frontier. I can't explain it. . . . I don't even know if it means anything.

T: An almost holy place, that is, in which you can see your fragility.

P: I can't explain it. I mean she wasn't annoyed with me because I was treading or I was threatening to. . . . She really made these things the very reason for her existence.



Elena shows how having—or, literally, causing—stains has always triggered a critical and threatening reaction from her mother. The result is that she has always been narcissistically self-reliant. At this moment she instead discovers that her mother had a concealed and deep-rooted feeling of fragility—exactly the same thing she discovered in herself. If the other is imperfect or creates problems (not knowing Schroedinger’s equation or dirtying the bathroom), one feels fragile and frightened.

A short time later the therapist self-disclosed in a transaction we find particularly amusing. Both display a perfectionist trait, but in the least likely field for an overt narcissist: cleaning toilets. We shall see that the episode has in fact serious implications and leads to a profound relational attunement.

- P: This is how my brother is: He’s very good, it’s true . . . he’s generous, but the other side of the coin is that he’s a very rigid person.
- T: But still I wanted to say “so your brother has a heart.”
- P: That’s for sure. He’s good.
- T: I mean . . . if I stick to one of your descriptions, your family seems to be like something from *Terminator* . . . does your brother stopping with the dog instead embody the image of a person ready to receive?
- P: There was a time when we used to spend Easter Monday with an old people’s club . . . every year there was the same problem: who’s going to take care of the toilets? Nobody wanted to . . . so of course me and my brother became ladies’ toilet cleaner and men’s toilet cleaner.
- T: Were they cleaned well?
- P: Yes, absolutely. I . . . I remember that I felt a bit embarrassed for the people, but I can’t see what harm there is in it.
- T: In cleaning toilets?
- P: Nothing.
- T: No, absolutely . . . I’m proud of cleaning the toilet, if I can . . . during my military service I was the best one at cleaning.
- P: I’ve become really good at it. Vim loves me!
- T: I prefer Ajax.
- P: Me too! Come on!
- T: And it’s no longer so easy to find it.
- P: I have. . . . But it isn’t just the toilet cleaning; there was something else too. That is, this elderly person turned up and needed to go to the toilet. Well, lots of them maybe need to be helped and so a person, I imagine, can feel a bit embarrassed.
- T: Why?
- P: Uh, it depends on the help one can get. . . .
- T: Well, I reckon you’re up to . . .
- P: I was thinking abstractly: that is, think of a person who perhaps . . . elderly, who doesn’t even know where they are and finds themselves alone . . . without someone to lend a hand, maybe they need help and feel embarrassed to ask.

This transaction has two important aspects. The first is that Elena mentions a family member who is able to provide care, her brother. She herself embodies this position in the narrative. The scene, moreover, is the same as in the episode with her mother, a dirty restroom. However, this time Elena is good at cleaning and is not criticized.

The second is that Elena sees a person, who is cared for, as being in need (the senior citizens) and not someone unworthy and inferior, who ought to hide out of shame. The caring for/cared for relationship pattern takes center stage in this narrative rather than the

dominant ones hitherto: weak person/contemptuous tyrant, incompetent/perfect. The therapist avoids embodying her critical mother and, in fact, adopts a position similar to that of her brother—someone not ashamed to take on humble roles and concern himself with dirt and illness. The self-disclosure was fundamental for this purpose, as was the dialogue in which both showed that they were experts on cleaning products. Self-disclosure and seeking of attunement are, we are convinced, fundamental parts of our therapeutic work with PD patients (Dimaggio et al., 2007).

In the subsequent sessions there was a repetition of this interpersonal cycle. Elena gave voice to the part that was weak and in need of help. A short time later she denied any feelings of fragility and entered a competition with the therapist, who usually only accepted the challenge temporarily. During these fluctuations Elena recalled many situations that made her realize that asking for help had always been a problem. Now she wanted to overcome this but did not know how to; the reason was that she, in fact, lacked a self-part able to ask for it spontaneously.

In session 5, Elena was the first to provide support to our working hypothesis: her inner world was limited because of the dysfunctional relationships during her development; the therapy was drawing out a self-part that had previously been nonexistent.

T: It seemed to me that you were about to cry.

P: No . . . I'm about to get somewhere . . . I have no objections. . . . You say that a person's identity gets shaped during a dialectical process. . . . Since various things happen to you, you have various choice options. But when I think, especially about when I was little, you know . . . all this variety is foreign to me. Here (*in therapy*), on the other hand, we talk about the sensation of the thing that grows, don't we? It's not something you can cut back . . . there's something that doesn't get formed . . . it's one thing if you've had something and then lost it tragically. But it's different if you've never had it because you've never been allowed to!

Elena realizes that the problem derives from her family history, in which caring was replaced by contempt and a struggle for power:

P: In the first place my family . . . the caring concept doesn't exist . . . it's practically something foreign . . . except for my father! The dominant position . . . it's not so much the fact that someone tells you . . . "Do what I say. I give you all these orders because what you want is rubbish and not worth anything!" But it's not so in reality. In reality there's an intrinsic mechanism: "I tell you externally what you have to do because what you want is against your own interests . . . ."

T: From what point of view?

P: My mother's.

During the first 4 months of therapy the themes listed previously recurred many times and were progressively enriched with the addition of new characters, emotions, and reflections. The importance of the conversation about the indeterminism principle is also clear. Elena needed to know that the therapist would not impose his knowledge and that what is observed can be modified by a change in viewpoint. This very abstract reasoning was a way of asking the therapist not to be tyrannical. As the abusing figure gradually made way for others, albeit remaining the dominant one for a long time both during sessions and in her daily life, characters capable of caring for Elena—in particular her boyfriend, who would comfort her when she cried—appeared.

With the help of the therapist, with his continuing self-disclosures of his own weak points, Elena talked of times at which she felt incapable at work. Even if with difficulty, she accepted that this was possible and that she should not despise herself. She acknowledged that her proud and perfectionist character arose during early childhood as a reaction to her feeling of being abandoned:

P: . . . I wanted to go with my sister, who was 1 year ahead of me, but instead they made me go to nursery school. And so I didn't want to go, not least because I thought that my mother wanted to abandon me. I clearly remember how tragic this was. . . . I learned to read on my own. . . I thought that if I could show I knew how to read, you see . . . they'd have put me in the first class with my sister! I was really disappointed when, in spite of my efforts, they said . . . that I couldn't join the class even if my reading was better than those who were in it.

After swinging back and forth from competition to reciprocal awareness of the other's intentions and empathy, the therapeutic relationship became stable and facilitative. Elena in the end was able to voice her fragile part and to modulate shame without having to conceal her flaws, as she supposed others would not attack or criticize her. She and the therapist agreed that the therapy could terminate and considered it successful.

#### *Outcome and Prognosis*

Outcome was excellent. Treatment consisted of 3 years of weekly individual psychotherapy, a total of 170 sessions, without medication. Elena had not been dismissed from her work position and found a job in an international organization in line with her qualifications and intelligence. Her professional relationships improved dramatically, and she found new friends. Instead of breaking off the relationship with her boyfriend, she married him. She acquired awareness of all the processes we have mentioned: the tendencies to compete, to distrust, and to despise both others and herself. This new awareness curbed her problematical tendencies. Her new self-parts—fragile and capable of asking for attention, caring and cooperative—became active in her daily life. All her depressive, anxiety, and suicidal symptoms were also absent at 3-year follow-up. Nor did she meet diagnostic criteria for personality disorder at the end of treatment.

Her remaining problems are that she finds it difficult to be very intimate with her partner; to have both an intellectual and a physical understanding simultaneously; and to experience orgasms from time to time. It is to be noted that difficulties in being intimate correspond to similar phenomena in the therapeutic relationship: right until the end, moments when ideas were shared were followed by a reactivated intellectual competitiveness. Elena, as she herself says, trusted the therapist but had difficulty in loosening up.

#### Clinical Issues and Summary

We believe that the work carried out by Elena's therapist has some prototypical elements that can be used by other clinicians tackling NPD. All narcissistic patients we have treated were characterized by limited forms of interpersonal relationship (Dimaggio et al., 2006) and subjective experience (Dimaggio, Nicolò, Fiore, et al., in press), similar to Elena's problems. A difficulty in asking for help, with the idea that the other will be contemptuous or tyrannical, and a tendency to compete and be self-sufficient are typical of the disorder. In all cases the therapists have found self-disclosure to be of benefit, especially when they felt the patients trusted them and they displayed their own failings or defects

and attuned to the patients' weaknesses. On the other hand, being caring toward the patients at too early a stage proved counterproductive, because it increased their diffidence and the interpersonal distance (Dimaggio et al., 2007). Finally, the successful therapies always involved an enrichment of the patient's inner world, with the entry on stage of characters capable of asking for and providing help and cooperating, and of characters looking critically at the tendency to compete. Such self-enrichment and meta-cognition improvement processes occur when a therapeutic relationship is handled correctly and seem to be typical of the treatment of all personality disorders.

Here and elsewhere (Dimaggio et al., 2006, 2007) we report a series of successful NPD cases treated with MIT; however, generalization of the positive result is possible only to a limited degree. Narcissism remains a difficult disorder to treat, because of the tendencies to competition and withdrawal, both of them a frequent cause of early dropouts. Our group is conducting a naturalistic outcome study on the efficacy of MIT for PD patients and preliminary data show that 8 of the 11 patients whose main diagnosis is NPD (according to SCID II) are still undergoing treatment after 1 year, with good outcomes on the symptom and global functioning scales. Less formal scrutiny of patients indicates that about of 80% of our NPD patients stay in treatment longer than 1 year.

Of note, SCID II is not a sensitive instrument for diagnosing NPD. This means that many other patients are considered narcissists by their therapists even in absence of a positive SCID II finding. These patients are likely to display even better therapy outcome. Nevertheless, there are many problems still to be solved (and controlled outcome studies to be conducted) to understand how these patients can be helped and how to prevent early dropouts.

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