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DEPRESSION IN NARCISSISTIC PERSONALITY DISORDER

The nefarious character Iago from Shakespeare's *Othello* demonstrates the devastating effect of unbridled narcissism combined with ruthless sociopathy. In Act 1, Scene 1, Iago vents his rage when he is not selected as Othello's officer:

But he [Othello], as loving his own pride and purposes,
Evades them, with a bombast circumstance
Horribly stuff'd with epithets of war:
And, in conclusion, nonsuits
My mediators; for Certes, says he,
I have already chose my officer.
And what was he?
Forsooth, a great arithmetician,
One Michael Cassio, a Florentine,
A fellow almost damn'd in a fair wife;
That never set a squadron in the field,
Nor the division of a battle knows
More than a spinster; unless the bookish theoretic,
Wherein the toged consuls can propose
As masterly as he: mere prattle without practice
Is all his soldiership. (Shakespeare, 1972, p. 1171)

In this brief passage, Iago evidences feelings of entitlement, and projection of his own narcissistic proclivities onto Othello. He denigrates Cassio, in thinly veiled jealousy of the latter's advancement. This specious reasoning—that he, Iago, is entitled to promotion because of his superiority—becomes the rationalization for his scheme to advance his position by undermining Othello.

PHENOMENOLOGY: THE EXPERIENCE OF NARCISSISTIC PERSONALITY DISORDER

Individuals with narcissistic personality disorder (PD) are prototypically haughty, arrogant, and grandiose. They are generally less active than Iago, prone to fantasy rather than actual aggression. What is striking about the phenomenology of narcissistic PD is not only how it impacts the person with the disorder but how it impacts others. When teaching, I ask my students to share experiences they have had with people who have characteristics of individuals with each of the PDs. I am consistently struck by the pained look of individuals who are children of narcissistic mothers or fathers. Dero- gation and consistent inability to ever satisfy the narcissist have been persistent themes. Equally interesting are the numerous stories of individuals who dated people with narcissistic PD just once, disappointed—though amused—at their dates' nonstop focus on themselves, inability to engage in a give-and- take conversation, or the crude and bombastic attempts to impress. Although these individuals were often good-looking, wealthy, well-appointed, and initially intriguing, it soon became evident that having a relationship with one of them would be not only undesirable but insufferable.

A colleague of mine (Suzanne Richter, personal communication, February 21, 2002) has provided a striking example of the impact of narcissistic PD on a child, even long into adulthood. The client, a woman in her 30s with a husband and two children, had been recently diagnosed with breast cancer and was preparing to undergo a mastectomy. Although she knew her mother was typically self-involved, she was hoping that her mother would at least be somewhat supportive under such extreme circumstances. When she informed her mother about her diagnosis and impending surgery, her mother responded, “Oh. Anyway, how do you like my dress that I'm wearing to the opera?” and stood up to provide a quick fashion show. The client was crushed. Perhaps the mother believed that she was helping by taking her daughter's mind off such a painful topic. Nonetheless, the empathic failure in this case is remarkable.

EPIDEMIOLOGY

Estimates indicate that the prevalence of narcissistic PD is less than 1% in the general population and is about 2% to 16% in clinical populations

(American Psychiatric Association, 2000a). In Pepper et al.'s (1995) dysthymic disorder sample, 4% had narcissistic PD. Markowitz, Moran, Kocsis, and Frances (1992) studied a sample of 34 outpatients with dysthymic disorder; 6% had narcissistic PD. Of the 116 individuals with major depression in a study by Zimmerman and Coryell (1989), 7.8% had narcissistic PD. In another sample of depressed clients, approximately 11% had narcissistic PD (Fava et al., 1995). In a sample of 352 clients with both anxiety and depression, approximately 6% had narcissistic PD as diagnosed by structured interview (Flick, Roy-Byrne, Cowley, Shores, & Dunner, 1993). Thus, in depressed samples, approximately 4% to 11% had narcissistic PD. Zimmerman and Coryell's (1989) study had no individuals with narcissistic PD; to my knowledge, no studies have assessed the frequency of depression in a sample of individuals with narcissistic PD.

WHY DO PEOPLE WITH NARCISSISTIC PERSONALITY DISORDER GET DEPRESSED?

Individuals with narcissistic PD often become depressed when their fantasies of unlimited success or admiration from others do not materialize. Noted Millon (1999),

Dysthymic disorder is perhaps the most common symptom disorder seen among narcissists. Faced with repeated failures and social humiliations, and unable to find some way of living up to their inflated self-image, narcissists may succumb to uncertainty and dissatisfaction, losing self-confidence, and convincing themselves that they are, and perhaps have always been, fraudulent and phony. (p. 244)

Drawing on psychodynamic and object relations perspectives, O. F. Kernberg (cited in Millon, 1999) described the mixture of fear, rage, and feelings of failure that constitute depression in the individual with narcissistic PD:

For them, to accept the breakdown of the illusion of grandiosity means to accept the dangerous, lingering awareness of the depreciated self—the hungry, empty, lonely primitive self surrounded by a world of dangerous, sadistically frustrating and revengeful objects. (p. 244)

Thus narcissistic PD appears to be a factor that increases one's vulnerability to depression. As with antisocial PD, however, it is likely that there is a "reverse exacerbation" of sorts, in that individuals with narcissistic PD and depression are likely more amenable to treatment than those with narcissistic PD alone (see chap. 2, this volume, for a discussion of theoretical models of the relationship between Axis I and Axis II disorders).

Depression in narcissistic PD can alternate between being hostile and being withdrawn and sullen. Often individuals compose themselves by returning to grandiose fantasies. If they can attain some level of success, then

the depression may dissipate. If not, however, reality continues to hit hard; repeated failures reignite the depression. Tending to blame others, persons with narcissistic PD may at times appear paranoid as they attempt to find an excuse for failing to live up to their own virtually unreachable expectations.

HOW A PERSON BECOMES AND REMAINS NARCISSISTIC: THEORIES OF NARCISSISTIC PERSONALITY DISORDER

Biological Factors

To my knowledge, there have been no studies of the neurobiology of grandiosity, arrogance, lack of empathy, or other narcissistic traits.¹ Millon (1996) noted that the biological mechanisms of narcissistic PD were not known. Other factors, such as heritability and medications, have received at least some attention.

Heritability

As with other PDs, narcissistic PD appears to be moderately heritable. In their study of the heritability of PDs in children and adolescents, Coolidge, Thede, and Jang (2001) found that narcissistic PD had a heritability of 66%. Livesley, Jang, and Vernon's (1998) twin study found that narcissism had a heritability of 43.6%.

Medications

Almost no studies have assessed the use of medications for individuals with narcissistic PD. The Ekselius and von Knorring (1998) study reviewed in chapter 1 of this volume included 37 individuals with narcissistic PD. Results were generally discouraging. Neither sertraline nor citalopram were associated with statistically significant reductions in diagnosed rates of narcissistic PD. The citalopram group decreased by a mean of 0.5 criterion pre- to posttreatment, which was significant; the sertraline group, however, decreased by a mean of only 0.2 criterion, which was nonsignificant. D. W. Black, Monahan, Wesner, Gabel, and Bowers (1996) found that narcissistic traits were not impacted by fluvoxamine, relative to placebo.

Given the extremely limited available data, it is appropriate to consider the hypotheses developed by Joseph (1997) on the basis of his clinical experience. He argued that the features of narcissistic PD, such as grandiosity, feelings of entitlement, and arrogance, can be conceptualized as symptoms of hypomania and thus treated with medications such as lithium and

¹On the basis of her clinical experience, Mary Francis Schneider (personal communication, January 3, 2006) has speculated that the empathic failure associated with narcissistic PD falls along the autistic spectrum. Although there is no empirical support for her theory at this time, I believe it is worthy of investigation.

anticonvulsants (e.g., carbamazepine or valproate). To the extent that persons with narcissistic PD show paranoia (e.g., feeling envious and believing others are envious of them), Joseph suggested that antipsychotic medications such as risperidone, olanzapine, or sertindole are efficacious. When the individual with narcissistic PD becomes depressed, Joseph recommended mood stabilizers, selective serotonin reuptake inhibitors, or a combination thereof.

It is not clear from a theoretical standpoint that manic grandiosity and narcissistic grandiosity are linked. According to Millon's (1996) theory, most individuals with narcissistic PD are passive and calm unless insulted. Biological research would help to clarify the neuroanatomical and neurochemical correlates of narcissistic PD, leading to potential medication strategies. Whether confirming Joseph's (1997) hypotheses or evaluating new ones, randomized clinical trials are necessary to verify the effectiveness of medication treatment for symptoms of narcissistic PD.

Psychological Factors

Within the biopsychosocial model (Millon, 1969), psychological considerations fall midway between the "micro" level biological factors (which involve considerations at the molecular level) and the "macro" level social factors (which involve interactions of entire cultures, often including hundreds of millions of people). The psychological approaches reviewed in the following sections attend to behavioral, cognitive, affective, unconscious, and interpersonal aspects of the person's functioning.

Millon's Theory

Within his theoretical framework, Millon considered the narcissist to be the passive, self-oriented type. Narcissists are variable along the pain-pleasure dimension, which is thus not entered specifically into the formulation of the personality. They are passive in that they expect to have their desires met without having to put forth any effort. The self-orientation indicates an independent style, not relying on others for gratification. Millon (1981) described the characteristics as follows:

Narcissism signifies that these individuals overvalue their personal worth, direct their affections toward themselves rather than others, and expect that others will not only recognize but cater to the high esteem in which narcissists hold themselves. . . . Narcissistic individuals are benignly arrogant . . . they operate on the fantastic assumption that their mere desire is justification for possessing whatever they seek. (pp. 158–159)

It is Millon's belief that narcissism results from early and excessive positive regard from the child's parents. The parents view the child as marvelously superior and talented, regardless of his or her actual accomplishments.

This aggrandizing attitude is internalized—learned—by the future narcissist. Further, their parents' doting models the subservience that persons with narcissistic PD come to expect from all with whom they interact (Millon, 1981).

Millon's (1981) view is in marked contrast to analytic viewpoints exemplified by O. F. Kernberg (1970/1986b) and Kohut (1971). Kernberg and Kohut saw narcissism as a defense against underlying feelings of worthlessness, emptiness, and boredom. One of Millon's subtypes, the compensatory, appears to be similar to the analytic description of narcissism. This subtype is a mixture of narcissistic and passive-aggressive/negativistic features (Bockian, 1990).

Millon's domain-level descriptions of narcissistic PD are given in Appendix B. Of the domains, the exploitive interpersonal conduct and admirable self-image are the most salient.

Cognitive-Behavioral Conceptualization and Interventions

Individuals with narcissistic PD are prone to thoughts such as "I am superior" and "Others should cater to my needs." Depending on their personal history, their core beliefs tend to vary. Millon's (1981) prototype would be an individual who has a deep well of parental overvaluation on which to draw. For such individuals, the core beliefs match the automatic thoughts, and they genuinely believe they are superior; in the case of persons with narcissistic PD and depression, they are typically perplexed by reality's failure to demonstrate this obvious truth. The prototype is someone born to royalty, who would, naturally, expect to be treated deferentially by his or her subjects. Individuals who fit in with modern psychodynamic formulations, such as those of O. F. Kernberg (1970/1986b) and Kohut (1971), would have substantially different profiles. Although superficially grandiose, underneath they harbor beliefs about inadequacy and worthlessness. Exhibit 9.1 outlines the thought processes of the two basic subgroups of narcissists. What is remarkable is that individuals with such different experiential histories can have such a similar superficial manifestation, yet it is clear from case material that this is in fact the empirical reality. Although not present in conscious awareness, for insecure narcissists the fear is that they are imposters and are not truly superior; this trepidation often lurks in the shadows of their awareness.

A. T. Beck, Freeman, and Davis (2004) noted that there are three key targets in treating someone with narcissistic PD: (a) increasing goal attainment and exploring the meaning of success; (b) improving empathy and awareness of others' rights; and (c) enhancing self-esteem and beliefs about self-worth. Breaking down grandiose expectations into more achievable steps can be extremely useful in treating the person with narcissistic PD. Dysfunctional thought records can be used to challenge all-or-none thinking such as, "Unless I'm the star of the show I'm a total failure." Problem-solving discussions can help to undo inappropriate behavior, by, for example, replacing fantasy with concrete steps toward goal attainment. Beliefs about self can be gently and supportively challenged when there is sufficient rapport; for example,

EXHIBIT 9.1
 Conceptualization of Narcissistic Personality Disorder: A Comparison of
 Millon (1981, 1996) and O. F. Kernberg (1986b, 1986c)

Millon narcissist (secure narcissist)	Analytic narcissist (O. F. Kernberg; Kohut, 1971; insecure narcissist)
Core belief	
I am perfect I am great I am superior to others	I am worthless I am an imposter
Experiential history	
Excessive praise, especially for aspects of the self that do not require effort (e.g., praise for being handsome, pretty, or cute) High expectations	Being put down, neglected
Intermediate beliefs	
If someone stands in my way, he should be destroyed. If others don't recognize my greatness, it is because they are fools.	I'll show them. If I make an effort and fail, that would be horrible. If I am not superior, then I'm horrible, because the average person is a loser. If others don't recognize my superiority, then they are idiots.
Automatic thoughts	
Putting forth effort is beneath me. Others should recognize my superiority and reward me for it.	I am better than any of these people. They are a bunch of stupid losers.

the strategy of emphasizing what might be gained by a more accepting stance toward criticism can facilitate growth (A. T. Beck et al., 2004).

A. T. Beck and his associates (A. T. Beck et al., 2004; A. T. Beck & Freeman, 1990) recommended some alternative beliefs that can be used as goals or benchmarks for the individual with narcissistic PD. Reframing grandiose narcissistic beliefs into more realistic ones can be extremely beneficial—for example, “I can be ordinary and be happy”; “One can be human, just like everyone else, and still be special”; “Relationships are experiences, not status symbols” (A. T. Beck et al., 2004, p. 266); and “To let the evaluations of others control my moods makes me dependent on them and out of control” (A. T. Beck & Freeman, 1990, p. 249).

Other techniques can also be aimed at the various difficulties that constitute narcissistic PD. For example, hypersensitivity to criticism (that triggers narcissistic rage) can be treated with systematic sensitization. Fantasies of unlimited success can be altered using imagery work; for example, a fan-

tasy of being a star of a Broadway show can be replaced with an image of starring (or even having a secondary role) in a local theater production. Such images should focus on deriving pleasure from the activity itself, not only from the applause or the “glory.” Finally, extensive use of role play and imaginal work can help the client to improve his or her empathic capabilities (A. T. Beck & Freeman, 1990).

Psychodynamic Therapy

Underlying narcissistic grandiosity, according to O. F. Kernberg (1970/1986b), is a defect of early object relations. He argued that severe narcissism does not reflect simply a fixation in early narcissistic stages of development and a simple lack of the normal course of development toward object love but that it is characterized by the simultaneous development of pathological forms of self-love and pathological forms of object love (O. F. Kernberg, 1970/1986b, p. 216). As shall be seen later, this is exactly opposite Kohut’s (1971) argument that narcissistic disorders are indeed fixations in a narcissistic period.

O. F. Kernberg (1970/1986b) asserted that what happens in the case of the narcissist is a “refusion” of the self and the object after the establishment of functional ego boundaries. The ideal self, ideal object, and actual self are fused into one internalized image. Thus, according to Kernberg,

It is as if they [narcissists] were saying, “I do not need to fear that I will be rejected for not living up to the ideal of myself which alone makes it possible for me to be loved by the ideal person I imagine would love me. That ideal person and my ideal image of that person and my real self are all one, and better than the ideal person whom I wanted to love me, so that I do not need anybody else any more.” In other words, the normal tension between actual self on the one hand, and ideal self and ideal object on the other, is eliminated by the building up of an inflated self concept within which the actual self and the ideal self and ideal object are confused. (O. F. Kernberg, 1970/1986b, p. 217)

O. F. Kernberg (1970/1986b) also stated that narcissists very often have backgrounds in which the parental figures are chronically cold with underlying aggressive feelings. The child may be used to fulfill the parents’ narcissistic ambitions to be brilliant or great. The child often occupies a critical role in such families, being either an only child or considered to be one with special talents or intelligence. The situation thus fosters a need to defend against envy to live up to high expectations. Once set into motion—once the real and idealized self and object images have been fused—the pattern becomes “extremely effective in perpetuating a vicious circle of self-admiration, depreciation of others, and eliminating all actual dependency” (O. F. Kernberg, 1970/1986b, p. 220).

O. F. Kernberg (1970/1986b) saw the narcissist as feeling deeply rooted emptiness, rage, and fear as a consequence of the pathological fusion of self

and object images. The destruction of the external object image entails the destruction of appropriate self images, leaving a feeling of emptiness. The inability to experience others as real and whole objects implies inadequate mirroring of the grandiose fantasies of the narcissist; in order to be admired, one must have relationships with real people.

Idealized people, on whom these patients seem to “depend,” regularly turn out to be projections of their own aggrandized self concept. . . . His attitude toward others is either deprecatory—he has extracted all he needs and tosses them aside—or fearful—others may attack, exploit, and force him to submit to them. At the bottom of this dichotomy lies a still deeper image of the relationship with external objects, precisely the one against which the patient has erected all these other pathological structures. It is the image of a hungry, enraged, empty self, full of impotent anger at being frustrated, and fearful of a world which seems as hateful and revengeful as the patient himself. (O. F. Kernberg, 1970/1986b, pp. 218–219)

Heinz Kohut's (1971) theory of narcissism is based on his clinical observations of numerous narcissistic clients. His theory differs from the others in that he saw narcissistic needs and endeavors as constituting a separate line of development, an essential and normal part of the growth process. Pathological narcissism, then, is a fixation to a point of development; the phase-appropriate conflicts, as with any fixation, remain unresolved and are thus neurotically acted out or repeated (Kohut, 1971; see also O. F. Kernberg, 1986a, 1986b, 1986c). The trauma that causes the fixation is generated by the parents:

As can be regularly ascertained, the essential genetic trauma is grounded in the parents' own narcissistic fixations, and the parent's narcissistic needs contribute decisively to the child's remaining enmeshed within the narcissistic web of the parent's personality . . . (Kohut, 1983, p. 186)

Kohut (1971) refused to actually describe behavioral and diagnostic attributes of narcissists. He maintained that the only reliable criterion for diagnosis is the spontaneous emergence of one of the narcissistic transferences. Others, however, have gleaned characteristics from throughout Kohut's work and have suggested the following criteria:

Sexually, they may report perverse fantasies or lack of interest in sex; socially, they may experience work inhibitions, difficulty in forming and maintaining relationships, or delinquent activities; and personally, they may demonstrate a lack of humor, little empathy for others' needs and feelings, pathologic lying, or hypochondriacal preoccupations. . . . Reactive increase in grandiosity because of perceived injury to self-esteem may appear in increased coldness, self-consciousness, stilted speech, and even hypomanic-like episodes. (Akhtar & Thomson, 1982, p. 14)

For Kohut, however, the critical feature was the type of transference manifest within therapy. He stated that there are two basic kinds of transferences that indicate narcissistic disorders (see Kohut, 1971). The first is the *idealizing* transference, in which the client sees the therapist as all good and perfect, re-creating the relationship with the idealized parental “*imago*”—the unrealistic image of perfection through which the infant or young child views his or her parents.

The second kind of transference, or *mirror* transference, is the reactivation of the grandiose self, that is, the undifferentiated omnipotence of infancy.

The mirror transference constitutes the therapeutic revival of the developmental stage in which the child attempts to retain a part of the original, all-embracing narcissism by concentrating perfection and power upon a grandiose self and by assigning all imperfections to the outside. (Kohut, 1983, pp. 187–188)

There are three specific types of mirror transference: (a) *merger* (through the extension of the grandiose self); (b) *alter-ego* or *twinship*; and (c) *the mirror transference in the narrower sense*, which is the one most often referred to by Kohut. In the merger transference, the analyst is not experienced as a separate entity but rather as a part of the analysand. This notion is similar to Kernbergian notions of the transference, and in fact a case of O. F. Kernberg’s (1986c) illustrates the phenomenon dramatically. Kernberg had pointed out some disparities between the content of the client’s discussions and his tone of voice. “The patient first had a startled reaction, and after I finished talking, he said that he had not been able to listen attentively to what I was saying, but that he had all of a sudden become aware of my presence” (O. F. Kernberg, 1986c, p. 279). The failure to even acknowledge the existence of others except perhaps to bolster one’s own self-esteem is a highly narcissistic reaction.

In the twinship transference, the analysand sees the analyst as a separate person but one very much like him- or herself. Meissner, reviewing Kohut, stated,

At a somewhat less primitive level of organization [than the merger transference], the activation of the grandiose self leads to the experiencing of the narcissistic object as similar to, and to that extent a reflection of, the grandiose self. In this variant, the object as such is preserved but is modified by the subject’s perception of it to suit his narcissistic needs. This form of transference is referred to as alter-ego or twinship transference. Clinically, dreams and fantasies referring to such alter-ego or twinship relationship with the analyst may be explicit. (Meissner, 1986, p. 417)

This is less archaic than the merger transference, but is still a primitive way of relating; it is rarely seen, even among narcissists.

The mirror transference in the narrower sense is the most thoroughly discussed by Kohut (1971) and thus presumably the most common or impor-

tant. In this case the analyst is experienced clearly as a separate person but only considered important when he or she is “mirroring,” or confirming, the analysand’s grandiose notions of him- or herself. It is the reenactment of “the gleam in the mother’s eye, which mirrors the child’s exhibitionistic display” (Kohut, 1971, p. 116). It is through the re-creation of this critical phase of development that Kohut believed the corrective reconstruction process can take place.

Narcissists do have relations with objects. However, according to Kohut (1971), the objects only have significance insofar as they are seen as extensions of the self. Kohut thus labeled these “self-objects,” inasmuch as the self and the object are largely fused. Obviously, seeing others as a part of oneself involves a great deal of denial or distortion, thus impairing the reality-testing capabilities of the individual.

Family Systems

Couples in which both partners have narcissistic PD have unique vulnerabilities that can be addressed in couples therapy. Kalogjera et al. (1998) described an approach based on Kohut’s self psychology. In broad terms, the problem of the narcissistic couple is that they fail to meet each other’s self-object needs, thus reactivating old wounds from childhood. Mirroring self-object needs include the need for healthy attention from a significant other, such as empathy and attentive listening. Twinship self-object needs include shared interests and the need for mutually gratifying physical contact. Idealizing self-object needs include the desire for respect and the capacity to see good and wonderful qualities in the other person. However, individuals with narcissistic PD tend to be self-absorbed and provide insufficiently for the partner’s self-object needs in all three domains. When injured, each withdraws or rages at the other, perpetuating a cycle of wounding and of empathic failure. Kalogjera et al. illustrated the phenomenon with the following vignette:

In a conjoint marital session, Bob expressed his feelings of disappointment and hurt that his father did not accept his advice regarding a legal matter. This was particularly painful to Bob, in light of the fact that he is an expert in this field. This is one of the few instances in which Bob was able to be open regarding his feelings about his family. He was expecting an empathic and validating response from Kathy. Instead, she looked at him in an icy manner and, in a cold tone, stated, “I don’t think that should be affecting you anymore.” At that point, Bob became visibly angry; he turned toward the therapist and, in an agitated voice, shouted, “Would you want to be married to a woman like this?” (p. 220)

Correcting the problem in relatedness requires that the therapist address, and show the couple how to redress, multiple levels of empathic failure simultaneously; in addition, it is necessary for the therapist to reener-

gize the feelings of hope and optimism that formed the initial attraction and idealization of the couple. Over time, this idealization is often worn away (de-idealization), and desires for reparations emerge in their stead (the curative fantasy).

As often happens in these cases, both members of the couple are wounded simultaneously. The therapist must address their needs without siding with either member of the couple, or, more accurately, siding with both equally and simultaneously. Kalogjera et al.'s (1998) case illustration is highly instructive:

Therapist (T): Bob, you felt very hurt . . . you very much wanted Kathy to know how you felt about your painful interactions [rejection] with your father. You hoped Kathy would understand your pain and help you deal with it. *(The therapist empathically expresses the identification of the narcissistic injury, the unfulfilled selfobject needs for mirroring and twinship, and recognition of curative fantasy.)*

Bob: Uhhuh *(visible diminution of signs of anger).*

T: Kathy, for you Bob seemed preoccupied with his relationship with his father . . . it felt as if his father was more important to him than you and your marriage. *(Again, the therapist empathically identifies narcissistic injury and unfulfilled selfobject needs for mirroring and twinship . . .)*

Kathy: Yeh *(she nods her agreement).* (p. 231)

Note how the therapist simultaneously addressed both members of the couple to prevent further narcissistic wounding and to promote an alliance. The therapy continued:

T: Bob and Kathy *(addressing both together, to provide mirroring for them as a couple and twinship by joining them, thereby enhancing cohesion of the marital bond),* due to feeling deeply hurt, you have not been able to understand and meet each other's needs *(empathic attunement and identification of selfobject failure).* You did not feel safe, and you both withdrew from each other *(identification of the defensive reaction to fear of narcissistic injury).* Since you perceived each other as uncaring and blaming, a lot of resentment has built up in both of you *(identification of a source of de-idealization and subsequent development of narcissistic rage).* The risk for both of you was being hurt and yet not being heard again *(repetition of traumatization from childhood mirroring selfobject failures).* As a consequence it became very difficult to invest emotionally in your partner and in your future *(identification of destruction of curative fantasy).* Your marriage became less important, and you started to have doubts about your commitment to it . . . you both withdrew from each other *(identifica-*

tion of idealizing selfobject failure and further weakening of the curative fantasy, and defensive withdrawal from the relationship). (p. 231)

After approximately 18 months of treatment, the couple was functioning much better. They were freer and more open and loving with one another and laughed together more, and their sex life became satisfying again. They had worked through many of their hurt feelings, and, in the process, each member of the couple experienced a dramatic reduction in narcissistic symptoms.

L. S. Benjamin (1996a) recommended a similar approach. Couples work can facilitate recognition of the narcissistic pattern, which can be a tricky balancing act; it would be easy to fall into a position that would be seen as blaming one member of the couple or the other. For example, noting, "You tried to do something special and felt unappreciated by her" feeds the narcissistic husband by making his wife the villain, whereas stating, "Each person in the couple contributes to the problem; let's look at what each of you is doing" fails to validate the narcissistic client and is too far from his worldview. Stating instead, for example, "You have been trying to make things work well, and you feel just devastated to hear that they aren't going as perfectly as you thought" allows the recognition of problematic aspects of the narcissistic pattern, positively framed, and avoids blame.

Individuals with narcissistic PD also often pair with individuals with dependent PD. For further discussion of the dependent–narcissistic couple, see chapter 12 of this volume.

COUNTERTRANSFERENCE

Therapists frequently have difficult emotional reactions when treating individuals with narcissistic PD. Therapists have narcissistic needs, among them the need to be acknowledged by the client, perhaps even appreciated, and another the need to see the client make progress to validate our perceptions of ourselves as competent therapists (Ivey, 1995; Kohut, 1971). Clients with narcissistic PD can be maximally frustrating to both of those needs. According to psychodynamic theory, their psychic structure is designed specifically to avoid acknowledging the contribution of others and to maintain the fantasy that they are completely self-sufficient. The withdrawal of the client leads to feelings of boredom, and his or her grandiosity pulls for feelings of anger and punitiveness. As was discussed in the chapter on antisocial PD, the therapist will be drawn to reject clients when they act in an infantile manner (e.g., relentlessly demanding attention and admiration like a 2-year-old). Analytically oriented thinkers relate this to the internal developmental process of the therapist, who rejected (or, more technically, whose superego rejected) the infantile self as part of maturation (Cooper, 1959/1986);

cognitively oriented theorists note the disappointment of the therapist whose patient does not change and who attributes the problem to his own incompetence (A. T. Beck et al., 2004).

Ironically, the client's defensive structure pulls for anger, rejection, and neglect, precisely the situations and feelings they were designed to avoid. It is natural, though countertherapeutic, for the therapist to reject the client in kind (Cooper, 1959/1986; O. F. Kernberg, 1970/1986b, 1974/1986c; Kohut, 1971). Similarly, the client's arrogant, haughty attitudes and criticism of the therapist can interfere with the therapist developing empathy for the client (A. T. Beck et al., 2004). Such emotions are difficult to handle and are at odds with the self-concept of most therapists. Conversely, the therapist must be careful not to be drawn into the client's aggrandizing comments (e.g., compliments and flattery), which can lead to collusion to avoid change or be a cover for the client's covetousness of the therapist's positive qualities or possessions (A. T. Beck et al., 2004).

Empirical studies support the kinds of reactions that have been reported in the literature. Betan, Heim, Conklin, and Westen (2005) collected a countertransference questionnaire from 181 clinicians; the instructions were to include clients that they had seen for at least eight sessions. Thirteen of the clients who were rated had narcissistic PD. The authors noted, "Clinicians reported feeling anger, resentment and dread in working with narcissistic personality disorder patients; feeling devalued and criticized by the patient; and finding themselves distracted, avoidant, and wishing to terminate treatment" (Betan et al., 2005, p. 894). A study of responses to a filmed vignette of an individual with narcissistic PD indicated that therapist trainees were most likely to feel fear (indicated by response choices *fearful*, *guarded*, *alarmed*, and *afraid*) and anger (*angry*, *frustrated*); other likely emotions were indicated by single items (*curious*, *pity*, *sad*, *dislike*). Informal discussions with participants indicated that the fear was that the client would either verbally attack the therapist or "lose it" in a fit of rage, and anger was generated by the client's supercilious and devaluing attitude (Bockian, 2002a; see chap. 1 for further details of this study).

I recall experiencing several such feelings and entrapments with a person I treated early in my training. The client was a law student and thus had access to the counseling center where I was an extern. Strikingly handsome, he was able to quickly attract and seduce women; however, there was one woman whom he desired but with whom he had numerous get-togethers and breakups. He was genuinely perplexed by his inability to maintain a relationship with her, or, more accurately, by her lack of sustained interest in him. During one of our sessions, he said to me, "You don't say very much." I made some neutral comment, such as "Tell me more about that." He responded, "If I had to pay you, I would just set up a mirror and talk to myself." I felt wounded by his devaluing comment and, internally, withdrew into intellectualization ("My, how interesting, is this a mirroring transference?"). I then discussed

with him my role in therapy and made some efforts to correct what I am certain were distortions on his part. The session felt empty and unsatisfying. Many years later, in preparing a lecture on narcissistic PD, I had a fantasy of a conversation that might have been:

Client: If I had to pay you, I would just set up a mirror and talk to myself.

Therapist: I'm wondering, did you consider how I might feel when you said that?

Client: Isn't that your job? If you can't take it, you shouldn't be a counselor.

Therapist: You're a law student. It was a yes or no question; please just answer yes or no. Did you consider how I might feel when you made your comment?

Client: No.

Therapist: Do you think that might have something to do with the difficulties you are having with your girlfriend?

Thus one possible approach to countertransference is to use it as a sensitive antenna to identify the transference—in this case, devaluation tinged with entitlement and aggression. What has happened in the here and now can then be related to the client's presenting complaint. If the client's presenting problem is relationship oriented—and it often is—then when you as therapist feel devalued, it is an opportunity to share how, within the context of the client's goals, the comment is devaluing. Such “transference comments” are likely to be effective only if a therapeutic relationship has been established in which the client has felt validated and understood, at least to some degree.

SOCIAL CONSIDERATIONS AND DIVERSITY

As noted in chapter 3, features of antisocial and narcissistic PDs were induced in randomly selected college-aged men in the famous Stanford prison experiment (Haney, Banks, & Zimbardo, 1973). Collins (1998) extended this finding by having college student participants rate behaviors as either masculine or feminine; consistently, the guard behaviors (dominance, aggression) were rated as masculine, whereas prisoner behaviors (depression, anxiety) were rated as feminine. Because all of the participants were the same gender and were randomly assigned, the only plausible explanation for the differences in behavior was social role. Social dominance, then, tends to elicit arrogance and oppressive behavior, whereas social status inferiority elicits feelings of helplessness, depression, and anxiety. Thus, one explanation of

the gender gap in narcissistic PD is the impact of male privilege and patriarchy on mental functioning.

Anthropologist Richard Castillo (1997) would agree with such an interpretation. In discussing gender differences in narcissistic PD, he observed,

The symptoms of narcissistic personality disorder appear to be more likely to occur in societies that are hierarchical and egocentric, for example, the United States. It is likely that persons with this disorder will belong to one or more dominant groups in social hierarchies. (p 106)

He further noted that the disorder is less likely to occur in egalitarian cultures, such as the Senoi Temiar of Malaysia, and to be adaptive in extremely egocentric cultures such as the Swat Putkhtun of northern Pakistan. For the typical clinician in the United States, the major subcultures of interest are Euro-American, Asian, Hispanic, Native American, and African American. It is likely that more sociocentric cultures such as those of Japan and China are less likely to produce narcissistic pathology. Hierarchies within Hindu culture may produce behaviors that appear to be narcissistic but are considered acceptable within the culture (e.g., the superior behavior of the Brahman relative to the obsequious behavior of an untouchable). Machismo in Hispanic culture may also produce "false positives" for narcissistic PD in what are considered acceptable behaviors within the culture. White Euro-Americans may be more prone to take privilege for granted and to not recognize that their expectations may be considered excessive from the standpoint of other, less empowered groups (Castillo, 1997).

STRENGTHS OF PERSONS WITH NARCISSISTIC PERSONALITY DISORDER

Traits that are seen in mild, subclinical, or normal-range narcissism entail many features that are highly valued in Western culture. Confidence is valuable in nearly any circumstance. Most individuals who have accomplished great achievements have a belief in themselves that is along the dimension of narcissistic PD. The belief that one's ideas are sufficiently valuable that others should invest time, energy, or money in supporting their actualization is a prerequisite to accomplishment. To a certain degree, what separates healthy self-valuation from pathological narcissism is the understanding that ordinarily, regardless of one's ability, one must work hard to achieve one's goals (Bockian, 1990).

TREATMENT PLANNING: SYNERGISTIC TREATMENT

Because the person with narcissistic PD is considered the passive-independent type, the logical goal is to balance the polarities by helping the

EXHIBIT 9.2
Therapeutic Strategies and Tactics for the
Prototypal Narcissistic Personality

STRATEGIC GOALS

Balance Polarities

- Stimulate active-modifying
- Encourage other focus

Counter Perpetuations

- Undo insubstantial illusions
- Acquire discipline and self-controls
- Reduce social inconsiderations

TACTICAL MODALITIES

- Moderate admirable self-image
- Dismantle interpersonal exploitation
- Control haughty behavior
- Diminish expansive cognitions

Note. From *Personality-Guided Therapy* (p. 443), by T. Millon, 1999, New York: John Wiley & Sons. Copyright 1999 by John Wiley & Sons. Reprinted with permission of John Wiley & Sons, Inc.

client to become more active and more attached to others. Several proclivities lead to the perpetuation of the narcissistic pattern; these tendencies must be undermined in order to make progress. The client's illusions of superiority interfere with actual efforts to accomplish anything. Failure to gain desperately desired admiration because of genuine lack of accomplishment or underachievement leads to further fantasy rather than redoubled efforts; this cycle leads to depression and other mental deterioration. Impulsive rage alienates these individuals from others, and thus from the support that may help them to reach their goals. Another mechanism of social alienation is withdrawal into fantasies of unlimited success. Once social isolation occurs, the feedback necessary to help ground the individual in reality is undermined, and he or she begins to slide increasingly down the slippery slope of illusion, delusion, and self-boosting fantasy. Thus, therapy should be geared to reduce illusions of superiority, increase the person's self-control, and decrease social alienation (see Exhibit 9.2). The long-term goals for depressed individuals with narcissistic PD, then, include encouraging them to set goals; increase activity level; and decrease arrogance, entitlement, and exploitation and helping them to gain control over their rage and to recognize their depression and cope with it more effectively (Bockian & Jongsma, 2001; Jongsma & Peterson, 1999).

The most effective treatment arranges catalytic sequences that synergize and build on one another. For the client with narcissistic PD and depression, motivation will often be problematic; thus the best initial interventions will

be those that offer the best hope of rapid change. Alternately querulous, irritable, and showing bravado, people who have both depression and narcissistic PD will typically first respond best to a humanistic approach (validation) to establish a strong working alliance. A delicate balance often arises between “feeding the narcissism” and providing appropriate validation. Reflecting back true statements that do not directly confirm the more grandiose claims works well (e.g., “It sounds like you have a number of accomplishments of which to be proud”), as does validating the feelings (e.g., “It must be very painful to feel so misunderstood so often”). Then, as recommended by Millon (1999), one may explore the client’s developmental history with the goal of gaining insight into the meaning of the client’s behaviors and attitudes. Cognitive and behavioral interventions can then help to functionally improve behavior and mood. If the depression is not so severe that it precludes psychotherapeutic improvement, then it is best to wait for some psychological improvements to occur before introducing psychopharmacological interventions; individuals with narcissistic PD can lose motivation to make psychological changes once the immediate crisis is resolved. Some, however, are more connected to the psychotherapy; the opportunity to have undivided attention from another person is often appealing to the individual with narcissistic PD. In that regard, long-term psychodynamic or psychoanalytic therapy can be comfortably accepted. Family therapy can help the individual to correct patterns of exploitiveness and derogatory communication in marital and parent–child relationships. Group therapy can be extremely helpful in correcting interpersonal patterns, though there are two cautions: The narcissistic client often flees in the face of confrontations that threaten to explode his or her illusions, and there is a risk of the person becoming a monopolizer in the group. If those two factors can be managed, then prospects are reasonably good. Ultimately, if it is impossible to challenge the illusions, then the therapy has failed, so it is incumbent on the group therapist to find a balance between support and confrontation within the group.

CASE EXAMPLE: TOMÁS

At the beginning of therapy, Tomás, a Hispanic man, was 38 years old. At that time, he was married and had two children, ages 6 and 9. Tomás had experienced homosexual urges since childhood. He began to visit pornographic Web sites, and finally, he began to have affairs with men. He was caught, which precipitated a divorce; shortly thereafter he began therapy. At the time that he presented for treatment, he was depressed, anxious, and suicidal.

Early in the treatment, Tomás wondered if he might be narcissistic. Reviewing the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text revision; American Psychiatric Association, 2000a) with

the therapist, Mark Johns, in a collaborative fashion allowed the client to recognize that the label fit. Recognition of the narcissistic pattern and insights into its nature and origins became a key feature of treatment.

Tomás was raised by two alcoholic parents. Although affectionate when sober, they were often emotionally neglectful. Forced to rely on himself, he always yearned for someone to fill his emotional hunger, to provide for his natural needs for mirroring and validation, and to care for him. His self-esteem was badly damaged, and he fit best into the “compensatory narcissist” conceptualization; his attempts at self-inflation were an effort to hide his underlying doubts and fears about his worthiness. He became preoccupied with fantasies of ideal love and supreme beauty and was consumed by concerns about his looks, weight, attractiveness to others and his desperate search for the ideal partner. Initially, Tomás believed that his attraction to men was temporary, a phase or just an expression of curiosity. As it became clearer that his primary sexual orientation was toward men, it precipitated a personal crisis. He felt dirty, guilty, and shameful.

Tomás had remarkably little empathy for his wife’s position. His main focus was on his own suffering, and he was perplexed that she was not supportive and understanding of the deep pain he was experiencing and had been experiencing throughout most of his life. Once divorced, he would share with her the intimate details of his sexual liaisons. His empathy was so poor that he did not fathom how hurtful this might be to her. Although his actions may have appeared to have a sadistic tinge, he did not appear to get satisfaction from hurting her or to be attempting to control her through intimidation. In part, his “sharing” was driven by a self-focus on his own pain without adequate consideration of his ex-wife’s needs. Despite the circumstances of their relationship, he felt entitled to her support. Ironically, although he had rejected his ex-wife, he felt even more rejected by her. He was covetous of her admiration, and his projection of his own negative feelings about himself led him to attempt to prove to her that he was attractive and desirable by boasting, if you will, about his relationships. His difficulties with empathy extended to his relationship with his children as well. Although he cared about them, their genuine needs were trumped by his concern for his image; he was primarily concerned about how his actions would make him look in the eyes of others or about how his children’s behaviors would reflect on him.

The initial phase of therapy focused on validating Tomás’s experience. The process of coming out and developing a gay identity is typically fraught with difficulties. Dr. Johns focused on the struggles that the client experienced and on his personal sense of pain. Tomás was taught mindfulness meditation, emotional regulation techniques, and distress tolerance (Kabat-Zinn, 1990; Linehan, 1993) as ways of coping with his pain. Like many individuals with narcissistic PD, Tomás initially had poor boundaries. He would call Dr. Johns very frequently, sometimes more than once per day, primarily to re-

lieve his anxiety. Dr. Johns used the model from dialectical behavior therapy (Linehan, 1993), in which phone calls could be used to reinforce coping skills, but if the phone call became lengthy, then an additional session was scheduled. This model worked well, and between-session phone calls gradually diminished over time. Once rapport had been adequately established, cognitive techniques (A. T. Beck et al., 2004) were used to correct Tomás's cognitive errors, particularly his black-and-white thinking.

There was a powerful pull for Dr. Johns to align with the wife and children and immediately push for the client to have greater empathy. To do so too early would have been a therapeutic error. The therapeutic relationship had to be solid before such work could be undertaken. Nonetheless, mindfulness meditation training (which has been shown to increase empathy levels) enhanced Dr. Johns's ability to sit with his own pain and thereby be more available to listen to Tomás. Later in therapy, after Tomás comprehended clearly that Dr. Johns understood and validated him and there was a strong therapeutic bond, direct interventions to help the client to put himself in his wife's and children's shoes was undertaken. There was progress in that area, which, though extremely slow, was a positive development for the client.

The main breakthrough in the case came when Dr. Johns suggested the use of the empty chair technique to help Tomás resolve the internalized split between his idealized and devalued self. Dr. Johns instructed the client to sit in a chair and have the "good self" talk to the "bad self," with the encouragement that they somehow find a way to come to terms with one another and develop a working relationship with each other. The good self was the straight, married-with-two-children, "perfect" (stereotypic) American male. The bad self was the gay, porn-watching adulterer. As the conversation evolved between the two, it became clear that the good self was also overbearing, judgmental, rigid, and insufferable, a manifestation of a domineering superego. The bad self was gentle, vulnerable, fallible but forgivable, and tender (and considerably more fun and likable). Apparently, the bad self was not all bad, nor was the good self all good. Given that the underlying need was to be loved (for which the need to be admired had been substituted but could never really fill the void), the good self would have to come to terms with the bad self. The bad self was the lovable one and offered the best hope of salvation.

Much of the client's depression was a function of his internalized homophobia. Raised Catholic, in a culture that promoted strong, stereotypically masculine roles, he had intense negative images of homosexuality. Being gay was associated with sinfulness, unmanliness, and worthlessness. As he developed a more affirmative and increasingly integrated gay identity, his depression lessened.

Countertransferentially, Dr. Johns often experienced feelings of irritation and frustration and, at times, exasperation. Tomás tried to build himself up at the expense of others, which went against Dr. Johns's values. The de-

valuation was at times directed at Dr. Johns, which elicited anger. Dr. Johns would attend closely to his own emotional reactions and then confront Tomás in the here and now, thus helping him to recognize how his behaviors and attitudes impacted other people. To reduce guilt and minimize projection of blame and responsibility as well as Tomás's own anger and resentment for being criticized, Dr. Johns would normalize Tomás's behavior within the context of his narcissistic PD or the problems he was confronting in his life. Although not excusing or condoning the behavior, Dr. Johns's method neutralized the potentially overwhelming affect and made the underlying issues more approachable.

Deep down, what Tomás feared the most was looking at the inner sense of emptiness that haunted him. Slowly, he came closer to getting in touch with those feelings. The mindfulness work was critical in that regard, because emptiness from a Buddhist perspective is not frightening; it is a crucial part of reality and, indeed, a necessary step in the path toward enlightenment.

In sum, then, guided by Tomás's personality and his need for unconditional positive regard, therapy started by using a humanistic approach, using empathy and validation and examining the client's thwarted actualizing tendency. The emphasis then shifted to cognitive-behavioral interventions to challenge Tomás's beliefs about himself and others. As his self-image improved, he became better able to tolerate more intensive self-exploration. Sensitivity to issues related to sexual orientation, ethnicity, and religion were crucial to understanding Tomás's depression. The use of mindfulness meditation helped him tolerate his negative affect sufficiently to engage in the therapeutic process. The use of the empty chair technique then allowed him to increase self-awareness and more thoroughly integrate aspects of self that he had previously abhorred or tried to ignore or destroy. Thus, therapies were combined synergistically, with a trusting relationship forming the foundation on which challenge could be tolerated; mindfulness-based stress reduction enhanced Tomás's insight and distress tolerance, which allowed deeper explorations of his issues with his therapist. Psychodynamic theory was helpful in examining the transference-countertransference interactions and understanding his self-development of and the dynamics underlying his interpersonal relationships, as well as helping to integrate his internalized parental images and childhood experiences into his present reality. As a function of the positive relationship with the therapist, modeling, and active and persistent skill building, Tomás slowly became more empathic. At this writing, group therapy or couples work are possibilities for helping him to further reduce his narcissistic proclivities. Further goals of treatment include increasing his ability to self-validate and decreasing his addictive proclivities (e.g., to relationships, sex, drugs, and food), which he was using to fill the void he was experiencing, as well as ameliorating the subsequent excessive admiration seeking, multiple sex partners, procrastination regarding priorities like finding a meaningful job, and sidestepping his role as parent.

SUMMARY AND CONCLUSIONS

When treating individuals with narcissistic PD, maintaining rapport is often a substantial challenge. Blithely supporting the narcissist's grandiosity all but abandons any hope of therapeutic progress, whereas confrontation undertaken precipitously can undermine a fragile bond. Managing countertransference is often the most difficult problem the therapist faces. In my experience, concurrent mild to moderate depression generally facilitates motivation, thus adding to the probability of therapeutic success. All of these elements were demonstrated in the case of Tomás. Initially, the focus was validation in order to secure the relationship. As the therapy evolved, Dr. Johns managed his countertransference using mindfulness-based techniques; when he (Dr. Johns) was more centered, he was able to compassionately confront the client's grandiosity and lack of empathy. Tomás's depression and PD resolved in concert with one another.

Depression in narcissistic PD requires a great deal of further research. Little is known about the biology of narcissistic PD, even though its heritability appears to be similar to that of other PD. Understanding the basic neurological mechanisms associated with the disorder may lead to improvements in both psychotherapy and medication management. Although I have argued that mild to moderate depression facilitates psychotherapeutic intervention with individuals with narcissistic PD, further research is needed to verify this hypothesis as well as to confirm other aspects of the relationship between depression and narcissistic PD.