


# A Psychodynamic Approach to the Diagnosis and Treatment of Closet Narcissism

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## Abstract

The purpose of this article was to increase awareness of an alternative presentation of narcissistic personality disorder, offer treatment strategies specifically geared toward such patients, and demonstrate how an understanding of object relations and defense mechanisms can guide interventions and improve diagnostic refinement. A case study was presented to illustrate this approach. This case study draws mainly from James Masterson's developmental, self, and object relations approach to the treatment of closet narcissism. Additional psychodynamic theories were also incorporated to provide a more comprehensive conceptualization of the client. Treatment consisted of psychodynamic therapy in which therapeutic neutrality, and analysis of the transference were core features.

## Keywords

closet narcissism, psychodynamic psychotherapy, object relations, separation-individuation, false self

## I Theoretical and Research Basis for Treatment

### *Subtypes of Narcissism*

A sense of superiority, a need for praise, and an inability to consider others' feelings and desires are among the diagnostic criteria of narcissistic personality disorder as listed in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev; *DSM-IV-TR*; American Psychiatric Association [APA], 2000). The *Psychodynamic Diagnostic Manual* (PDM; PDM Task Force, 2006) offers a description of the "Arrogant/Entitled" narcissist, which is similar to the narcissistic personality as depicted in the *DSM-IV-TR* (APA, 2000) and highlights the gregarious and interpersonally exploitative nature of this individual. However, unlike the *DSM-IV-TR* (APA, 2000), the *PDM* (PDM Task Force, 2006) delineates an alternative presentation of narcissistic pathology referred to as the Depressed/Depleted subtype. Numerous psychologists have recognized this less well-known presentation of narcissism and have referred to it by varying names,

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including the “covert narcissist” (Akhtar & Thompson, 1982; Wink, 1991), “closet narcissist” (Masterson, 1993), the “hypervigilant narcissist” (Gabbard, 2009), and the “hypersensitive narcissist” (Hendin & Cheek, 1997).

Despite distinct differences between the Arrogant/Entitled and the Depressed/Depleted forms of narcissism, they do show some of the same characteristics of entitlement, preoccupation with grandiosity, a lack of empathy, self-indulgence, and selfishness (Pincus et al., 2009). According to James Masterson (1993), the Depressed/Depleted and the Arrogant/Entitled subtypes can be differentiated by the nature of the “false self” that is expressed. More specifically, the Arrogant/Entitled subtype or the “exhibitionist narcissist” devalues others and boasts about the self, whereas the Depressed/Depleted subtype or the “closet narcissist” praises others and devalues the self. Furthermore, whereas the exhibitionist narcissist is intent on receiving attention and admiration from others, the closet narcissist is obsessed with his or her unfilled expectations of the self. Consequently, the closet narcissist is absorbed in grandiose fantasies that are unrealistic given the individual’s lack of initiative and self-confidence (Wink, 1991). Other defining features of the closet narcissist include a shy and modest demeanor, hypersensitivity to criticism and failure, and shame related to unachieved goals. In addition, the closet narcissist often admires and idealizes those who are successful; however, he or she secretly experiences envy of and resentment toward them (Wink, 1991). The individual’s tendency to idealize others predicts such an occurrence in the therapeutic relationship, which masks the closet narcissist’s largely unconscious feelings of grandiosity (Kernberg, 1986), making the diagnosis of the disorder especially challenging for clinicians. Moreover, a lack of knowledge about this subtype can result in diagnostic conclusions and treatment approaches that are either ineffective or lead to premature termination (Masterson, 1993). Therefore, this current case of Edward aimed to increase the understanding of closet narcissism by demonstrating the diagnosis and treatment of the disorder utilizing James Masterson’s (1981, 1993) developmental, self, and object relations approach and incorporating aspects of other psychodynamic theories and techniques.

### *Developmental, Self, and Object Relations Theory*

Masterson (1993) considers the developmental arrest of the self (i.e., false self development) to be the primary issue in personality disorders, which he describes in terms of Margaret Mahler’s separation-individuation theory. Separation implies the development of boundaries, the differentiation between the infant and the primary caretaker, whereas individuation refers to the development of the infant’s ego, sense of identity, and cognitive abilities. According to Mahler (1975), separation-individuation marks the beginning of the baby’s emergence from a symbiotic relationship with the primary caretaker and includes four subphases: (a) differentiation, (b) practicing, (c) rapprochement, and (d) on-the-way-to-object-constancy.

Of most relevance to the development of narcissistic personality disorder is the practicing phase (10-12 months to 16-24 months) during which the infant’s cognitive and motor skills improve as the child is able to explore his or her surroundings without the primary caretaker’s assistance (Masterson, 1993). This time period represents the height of narcissism as the child perceives of the parent as his or her need-gratifying object and feels impermeable to falls and other setbacks because, as center of the universe, the primary caretaker will be there to “catch” him or her. Nevertheless, he or she still depends on the parent for emotional recharging when faced with inevitable falls and disappointments. Ideally, the caregiver provides the necessary support that teaches the infant that the pain will ultimately be relieved. This parent is able to put his or her own needs and anxieties aside to mirror the child’s emotional needs. Moreover, the caretaker must assure the child that negative affective experiences in response to disappointments (and exhibitionism) will gradually fade so that this understanding is internalized and used

to self-soothe. In such cases, the child will eventually achieve the healthy amount of self-esteem necessary to independently pursue goals and handle life's struggles.

At approximately 17 to 24 months, the rapprochement subphase begins and is associated with upright exploration. Upright exploration is also accompanied by separation anxiety, and by the end of the practicing period, the child's representation of the self and object becomes increasingly distinct. The infant begins to lose his or her sense of grandiosity and omnipotence, realizes that he or she must cope with the world independently from the primary caretaker, and develops a more realistic view of the self in relationship to the world (Mahler, 1975). However, if the parent did not mirror the child's omnipotence and grandiosity during the practicing period, a healthy level of narcissism is not achieved. Therefore, Masterson (1993) views narcissistic pathology as the product of a developmental arrest that takes place before the child reaches the end of the practicing period as the narcissistic adult's grandiosity remains at the high level observed in infancy. Consequently, the individual appears stuck in a phase of development that entails a constant need for "narcissistic supplies" and perfect mirroring.

With regard to the closet narcissist's interactions with his or her primary caregiver, Masterson (1993) explains that the parent often disparages and humiliates the child for displaying infantile narcissism and real self-needs. As the child is expected to idealize the parent and thereby mirror the parent's grandiose self, the child must learn to hide his or her own grandiosity and emotional needs from the parent. Thus, the child is forced to suppress the real self to receive basic approval.

Based on the closet narcissist's early interactions with his or her primary caretaker, the individual internalizes "object relations," or representations of interpersonal relationships that serve as a template for future relationships. More specifically, the closet narcissist's internal world consists of two "object relations units" that are each associated with a separate set of relational events and include a self-representation or image of the self, object representation or image of the primary caretaker, and a linking affective experience. As the closet narcissist's parent did not encourage separation and individuation, leaving him or her developmentally arrested in the practicing phase, the individual maintains the belief that the object, or mother, is an extension of the self. Therefore, although the closet narcissist acknowledges his or her physical separation from the object, self-representations and object representations appear "fused" because the individual perceives the self and object as one-minded.

Regarding the specific aspects of the fused self-object units, there is a unit that represents the parent's reaction to the child when he or she behaved in a way that did not meet the parent's needs, wishes, and expectations (i.e., object as devaluing) and the child's feelings about the self during such interactions (i.e., self as marred). Whenever this unit is activated, the individual experiences the affective state of the "abandonment depression"—fragmentation, shame, envy, and a sense of the self "falling apart" (Masterson, 1993). The other unit contains memories of the periods when the child and the parent were in accord (i.e., self as grandiose, object as omnipotent) and is connected to feeling special and admired. As the closet narcissist idealizes the perfection of the object and, in turn, shares in this sense of perfection, continued idealization of and fusion with the object is required to maintain the individual's self-esteem and to prevent him or her from the abandonment depression affects. However, a break in fusion will occur when the idealized object criticizes or disagrees with the individual and during interactions that involve intimacy, empathy, vulnerability or discussing, and understanding feelings. In response, the closet narcissist will display the "disorders of the self triad": (a) self-activation, or the pursuit of real-self goals incites the (b) abandonment depression and results in the use of (c) defenses (Masterson, 1981, 1993). As self-activation entails unveiling the real self rather than focusing on the needs of the idealized object, it triggers the feelings of emptiness, shame, humiliation, envy, and rage (i.e., abandonment depression affects) that are linked to internal representations of the primary caregiver's response to displays of grandiosity. To defend against these feelings, the

individual will use any number of defenses that are characteristic of his or her false self, including devaluation of the self, idealization of the object, or self-destructive behaviors (Masterson, 1993). Although perceived criticism, incongruent thinking between self and object, and self-assertive behaviors induce the affective experiences of the abandonment depression, **more severe symptoms of a clinical depression manifest when the closet narcissist faces real or threatened separation from an idealized object (Masterson, 1993).**

## 2 Case Introduction

Edward, a **40-year-old male** of Euro-Caucasian descent was self-referred for treatment at a community mental health center. At intake, he presented as unemployed and single and reported **living with his primary caretaker**. He also brought in the results of several neuropsychological tests from 19 years, 16 years, 12 years, 10 years, 4 years, and 6 months prior to intake. His intake evaluation consisted of a clinical interview that was conducted by this therapist.

## 3 Presenting Complaints

When discussing his reasons for seeking therapy, Edward reported **feeling as though he was “living in a personal hell.”** He described himself as **“worthless and profoundly flawed”** and **indicated that he feels “tortured by envy every second of every day.”** He further noted an inability to derive pleasure from daily activities, concerns about his anxiety-related tremor, and a **“fear of failing.”** Edward described feeling so insecure about his own abilities that he internalized the words of admired others such as philosophers, poets, and musicians so that he could quote them in conversation and thus feel inflated.

Interpersonally, Edward explained that he generally experiences difficulties relating to others and thinks that people no longer want to associate with “someone like [him]” after they discover he has a “neurological problem.” Upon further elaboration about his neurological concerns, Edward stated that he believes he has “memory problems” because he is unable to recall, verbatim, everything he reads. He also noted that, due to the large discrepancy between his verbal skills and his mathematic abilities, he feels as though he is “living with two brains—one of which is intelligent and hyper-aware of the other which is retarded.” In discussing his treatment goals, Edward expressed a desire to find out what is “wrong” with him and why, if he does not have a serious intellectual impairment, others function “light years beyond” him.

### *History of Presenting Problem*

In terms of his affective symptoms, Edward expressed that, although he has always felt “inadequate” and “inferior,” his depressive tendencies intensified into constant suicidal ideations, an inability to leave his bed for several weeks, and a complete loss of appetite, following the realization, about 10 months earlier, he could never truly be with a woman he claimed to love. Edward stated that shortly after he met this woman, he made plans to move to her city and potentially marry her, despite his awareness that she was married to another man. Edward described this woman as representing everything he wished he could be and noted fantasies of “merging” with her. Edward further reported that when he came to accept that his fantasy could never be a reality, he began ruminating about his failure to meet his educational goals, to become a “revolutionary,” and to generally pursue “omnipotence.”

With respect to his relational difficulties, Edward attributed his interpersonal issues to having a neurological problem since birth that impairs his social skills. When asked about his belief that people reject him after finding out he has a “neurological problem,” he responded that people do

not want to associate with someone who is “damaged.” However, he angrily stated that others often tell him he does not have a brain problem and that he should “just get over it.”

Edward recalled that he first began to believe that he had a neurological problem when he was in gym class at 7 years old. According to Edward, when his teacher was instructing the class on how to tie their shoelaces, he and the “retarded girl” were the only students who struggled with the task. When asked how this situation made him feel, Edward replied, “it made me feel like I was mentally retarded as well.” Because of this conviction, at the age of 18 years old, Edward began completing a series of neuropsychological evaluations in an effort to seek confirmation of what he suspected was a “profound disorder.” Edward stated that he continues to repeat such assessments because he believes that the results have been inaccurate, and he wants to find out the true extent of his impairments before pursuing his goal of attaining a “PhD in neuropsychology.”

## 4 History

### *Family History*

Edward is an only child who was born in the northeast United States and currently lives with his biological mother. When he was 10 years old, his parents separated and he relocated to the southeast with his mother. His parents officially divorced 3 years later. Edward’s biological father currently lives in the northeast with his stepmother and half-sister. Edward stated that he typically sees his father about once a year.

Edward described his father as passive, unfaithful, and disinterested in Edward’s life. According to Edward, during his childhood, his father demonstrated affection by building World War II aircraft models with him, however, Edward pointed out that he usually just watched his father build them. According to Edward, his father did not know how to handle him while he was growing up.

Edward described his mother as “beautiful,” “extremely intelligent,” and “close to human perfection.” However, he noted his mother’s disparaging treatment of him; for instance, Edward recalled his mother yelling “you little asshole” from the bleachers when he would consistently strike out during little league baseball games. He also mentioned that throughout his life, his mother has been “angry and overbearing” and “screams a lot for everything.” He recalled an incident from the age of 5 or 6 when his mother was attempting to help him with his math homework; he explained that when he was having a difficult time grasping the concept, his mother became extremely frustrated and began “slamming the table, screaming, and cursing,” as well as “threatening and insulting” him. Finally, he noted that, according to his uncle and father, when Edward was between 1 and 2 years old, they successfully intervened before Edward’s mother “threw [him] into a wall.”

### *Relationship History*

Edward stated that he had a girlfriend for about 5 years who was a “professional dominatrix.” Edward explained that initially he enjoyed having sexual relations with her, but as the relationship became more emotionally intimate, he no longer found her attractive or sexually arousing. Edward noted that his ex-girlfriend would become angry when he did not want to have sexual relations with her and also tried to prevent him from masturbating.

Edward reported that he regularly seeks sexual gratification from strippers, prostitutes, and through random individuals on an Internet website. He discussed his preference for masochistic sexual experiences and expressed frustration related to his sexual desires; he stated that he wished

he could control his sexual urges and thoughts. He also claimed that he would prefer not having a sex drive at all as it distracts him daily from his goals and drains his money.

Edward explained that he met the woman he currently is in love with on the Internet. He admitted that he had lied to her about his occupation; specifically, he said he was a marine biologist who had not been active in the field for the past couple of years because he was running a successful clothing business. When asked why he felt the need to lie, Edward replied, "because no one would want to be with someone like me."

### *Social History*

Edward reported that throughout his childhood, he was severely bullied. He claimed that when he was 6 years old, a group of his peers held him down while "a girl beat [him] up." He further noted that his classmates would throw rocks at him and call him names. Edward also recalled a time when his "so-called friends" locked him in the trunk of their car while they sped around the city.

Edward noted having a best friend of 12 years whom he met during college. However, he clarified that this friend was incarcerated for about 7 of those years. According to Edward, although he did not agree with some of his friend's past behaviors, their friendship persisted because this friend never "mocked" him like others in his life have.

### *Medical, Educational, and Developmental History*

Edward denied a history of traumatic head injury or loss of consciousness. He stated that he never repeated a grade or took special classes and reported that his grades in school ranged from As to Fs, with mostly Cs and Ds. He dropped out of high school before beginning his senior year, but eventually completed the general equivalency diploma tests at 24 years of age. He received a waiver of math requirements to attain an associate of arts degree, which he achieved at the age of 34. Although he stated that English is a relative strength for him, he admitted that he earned an F in an English class during college. The results of previous neuropsychological tests revealed scores within the average to above average range on all intelligence and achievement measures.

## **5 Assessment**

Edward completed a psychological evaluation once the therapeutic alliance was established that served to inform the treatment process. The following self-report measures and projective tests were administered by a separate therapist: the Minnesota Multiphasic Personality Inventory–Second Edition (MMPI-II; Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), the Millon Clinical Multiaxial Inventory–Third Edition (MCMI-III; Millon, Millon, Davis, & Grossman, 2006), the Hypersensitive Narcissism Scale (HSNS; Hendin & Cheek, 1997), the Rorschach (Rorschach, 1921), and the House-Tree-Person projective drawings (H-T-P; Buck, 1948).

According to the assessment results, Edward experiences anxiety, depressive affect, ruminations, a preoccupation with masculinity, sexual inadequacy, and psychosomatic concerns. He scored similar to those with prominent personality problems and disorders, as he is likely non-conforming and may at times feel little empathy toward others (Choca, 2004; Exner, 2003; Graham, 2006). Despite significant affective problems, it seems that these are secondary to a consistent difficulty with creating and maintaining effective and rewarding interpersonal relationships as his emotions tend to vary as his support system strengthens and weakens (Choca, 2004; Exner, 2003; Graham, 2006).



In terms of his coping strategies and defenses, the test findings suggested that Edward generally feels very uncomfortable coping with emotion, and is likely emotionally guarded and defensive (Choca, 2004; Exner, 2003; Graham, 2006). He appears to rely on intellectualization and fantasy in attempting to deal with issues of self-image and self-value (Choca, 2004; Exner, 2003; Graham, 2006). Furthermore, although he may reveal grandiose tendencies, these are accompanied by feelings of inadequacy with compensatory defenses (Wenck, 1977).

Regarding others' perception of Edward, the test results indicated that he is likely viewed as resentful, antagonistic, critical, rigid, eccentric, aloof, distant, socially immature, limited in social skills, and in conflict with societal values (Choca, 2004; Exner, 2003; Graham, 2006). He may present himself as inferior, self-effacing, insecure, or otherwise reluctant to accept pleasure and happiness. Although he may feel depressed, anxious, and worthless, people are likely to question the sincerity of these statements (Choca, 2004; Exner, 2003).

With respect to his interpersonal perception and relatedness, Edward scored similar to individuals who are suspicious, untrusting, withdrawn, and introverted (Choca, 2004; Graham, 2006). He is likely extremely sensitive to real or imagined criticism, may personalize neutral remarks, and is prone to become highly defensive in situations where perceived challenges to the self arise (Exner, 2003; Wenck, 1977).

In the areas of self-perception and needs, Edward's scores indicated a tendency to set high standards for himself and to experience a sense of guilt and shame when those standards are not met (Choca, 2004; Exner, 2003; Graham, 2006; Wenck, 1977). As such, Edward likely feels dissatisfied with and frustrated by his own lack of accomplishment (Choca, 2004; Graham, 2006). He may regularly compare himself with others, and as a result, feel self-conscious, inadequate, inferior, and ashamed (Choca, 2004; Graham, 2006). Moreover, Edward appears to have a strong need for achievement but is afraid to compete for fear of failing (Choca, 2004; Exner, 2003; Graham, 2006; Wenck, 1977).

### *Diagnostic Conclusions and Differential Diagnosis*

Because Edward's psychological testing results indicated the centrality of his personality disorder features and interpersonal problems, his personality disorder diagnosis was emphasized in treatment. Edward's presentation is consistent with the *PDM's* (2006) **Depressed/Depleted subtype (P104.2) of narcissistic personality as these individuals seek people to idealize, are easily wounded, and feel envy toward others viewed as superior** (PDM Task Force, 2006).

**According to Masterson (1981, 1993), among the most common diagnostic errors made when working with closet narcissism is mistaking the disorder for borderline personality disorder. A crucial difference between closet narcissism and borderline personality is that the former is concerned with being perfect, whereas the latter seeks unconditional acceptance and love. However, both present with fragile self-esteem, depressive affect, and clinging behavior.**

Borderline personality disorder was initially considered because of Edward's reported chronic feelings of emptiness, intense anger, and impulsivity in terms of spending and sex. However, it was ultimately ruled out because **Edward indicated that he wished to be "omnipotent" and would not feel satisfied with himself unless he was superior in all aspects of measured intelligence.**

An additional diagnosis of major depressive disorder is warranted as Edward appears to have had depressive episodes that consist of **symptoms such as depressed mood, loss of interest and pleasure, loss of energy, feelings of worthlessness, and decreased appetite.** A diagnosis of obsessive-compulsive disorder was considered given Edward's substantial stress that stems from persistent thoughts about having a "defected" brain but was ruled out as his brooding was ego-syntonic, whereas in obsessive-compulsive disorder, the thoughts are ego-dystonic. A diagnosis of generalized anxiety disorder was considered due to his excessive worry; however, his

anxiety and ruminations are mainly related to a more specific concern with his intelligence. Although he has completed numerous neuropsychological evaluations that fail to discover the existence of memory problems, he continues to believe “something has been missed.” Nevertheless, he is able to consider the possibility that he does not actually have a serious cognitive defect; Edward has gone as far as saying “it might all be in my head,” thus constituting a rule out of delusional disorder. According to Masterson (1993), somatic-like symptoms are especially common among individuals with closet narcissism as the patient may feel as though he or she is broken upon separation from an idealized object. Therefore, Edward’s preoccupation with his perceived cognitive limitations appears to be a symptom of his closet narcissistic personality disorder because it is most intense when he no longer feels merged with an idealized object.

To address Edward’s presenting concern regarding a possible brain/memory issue, his medical history and previous neuropsychological evaluations were thoroughly reviewed. First, brain damage was ruled out given an absence of head injury in Edward’s history. Next, because his intellectual skills remained consistent over a period of approximately 20 years (as measured on the Wechsler Adult Intelligence Scale-III [WAIS-III] and WAIS-IV), a degenerative disease or other progressive organic impairment is unlikely. A mathematics disorder was also ruled out because Edward scored in the average range on math achievement tests administered as part of a comprehensive neuropsychological exam. A diagnosis of developmental coordination disorder was considered because of Edward’s reported delay in acquiring the ability to tie his shoelaces, but was ruled out because Edward’s current motor issues seem to be anxiety based (i.e., his anxiety-related tremor). Despite these rule outs, in the absence of a magnetic resonance imaging (MRI) examination, no definitive conclusions can be made regarding the existence of a brain abnormality.

Edward also met *DSM-IV-TR* diagnostic criteria for sexual masochism that includes recurrent, intense sexually arousing fantasies; sexual urges; behaviors involving the act of being humiliated, beaten, bound, or otherwise made to suffer for over a period of at least 6 months; and fantasies, sexual urges, or behaviors that cause clinically significant impairment in social, occupational, or other important areas of functioning.

## 6 Case Conceptualization

When Edward was between 1 and 2 years old (during Mahler’s practicing phase), in the presence of his uncle and father, Edward’s primary caretaker almost harmed him physically (by throwing him into a wall). This episode occurred at the time when Edward’s grandiosity had reached its height and he was taking advantage of newfound skills that allowed him to explore his environment and begin separating from his mother. Edward’s interpretation of his primary caretaker’s behavior was that she wanted to punish him for displaying his grandiosity, beginning to separate, and focusing on his own needs. Moreover, as Edward’s mother was unavailable to soothe and refuel him after he endured the fears and falls of the practicing period, he experienced separations as painful and came to believe that his affective needs were unacceptable and shameful. When the client’s mother was a child, her caregiver(s) most likely did not treat her empathically; thus, she sought to receive from her own child the mirroring she was denied. Accepting his dependence on his mother, Edward learned to hide his grandiose desires and drives toward independence to please her and eventually others.

During his childhood and adolescent years, Edward continued to face a harsh interpersonal environment. Whenever he engaged in activities that he enjoyed or put in extra efforts to succeed in school, Edward’s mother would respond by humiliating and rejecting him. Edward also experienced regular bullying by his classmates of a verbal and physical nature. Edward explained that, because of these negative relational experiences, he grew up “terrified and ashamed” to speak to anyone about his feelings. Consequently, Edward split his personality into the repressed real self



that contains his grandiosity and affective needs and the false self that he presents to the world. Edward's false self is self-disparaging and self-defeating, and conceals his true potential and emotions. His real self is kept hidden out of fear that it will cause further humiliation and rejection.

Because Edward's mother did not encourage or support his growth into an independent and resilient individual, this fostered a conflict around assertiveness and success. A major component of Edward's false self presentation involves a defensive system organized around the idea that he has a defective brain. Conversely, Edward's real self contains the secret belief that he is an "unsculptured genius." According to Edward, if he discovered through additional schooling that he is not an "unsculptured genius," it would be "too devastating to handle." Because attempting to achieve his educational goals would require confronting reality-based difficulties and setbacks (in the absence of an acquired capacity to self-soothe), Edward would be forced to challenge the grandiose and omnipotent image of himself (i.e., as a genius) that was never modulated by a "good enough" mother's mirroring. Thus, by continuing to complete neuropsychological evaluations rather than actually pursuing his proclaimed goals, Edward is able to defend against the rapprochement crisis (e.g., ego deflation, awareness of idealized object's separateness) and maintain his grandiose illusions about the self.

In an attempt to master the traumas of his pre-adulthood, Edward reverses early states of helplessness and passivity by creating them himself in the present, specifically in the form of sexual masochism. According to Edward, he experiences a sense of control and power when engaging in sexual masochism because he is making the choice to feel punished and shamed. In contrast to the humiliation and pain that occurred spontaneously throughout his childhood and adolescence, when engaging in sexual masochism, he is able to control the timing of and the degree to which he is hurt. However, Edward's attempts at mastery have resulted in a repetition compulsion, possibly because masochistic surrender allows Edward to fuse with a more powerful, idealized object, and thus defend against separation-individuation.

Given that Edward's early interactions with his mother set the template for later relationships, he acts out his deflated false self in interactions with admired others and idealizes them in the same way his mother demanded. Moreover, like the infant who draws strength from the omnipotence of the caregiver, Edward continues to rely on fusion with an idealized object to derive a more inflated sense of self. As Edward feels a sense of shame and inferiority specifically related to unachieved educational goals, he often idealizes women whose accomplishments he desires (e.g., the women he met online and this therapist) so that by merging with them, he can feel as though their successes are his own.

According to Masterson (1991), closet narcissists often develop a clinical syndrome after the loss of an object. Several months prior to entering treatment, Edward felt good about himself because he had merged with a woman who evidenced the qualities that he wished to possess (e.g., graduate education, no brain impairments, young age, etc.). However, because of his primitive defensive structure, Edward was oblivious to indications of this woman's unavailability. When Edward came to the realization that he could never truly be with this woman because she was married, he experienced a heightened awareness of his unachieved goals and an intense sense of worthlessness, shame, fragmentation, and failure. Thus, upon separation from the idealized object, Edward's idealization and fusion defenses failed, which resulted in the onset of a major depressive episode.

## 7 Course of Treatment and Assessment of Progress

Over the course of a year, Edward attended 48 weekly sessions of psychodynamic psychotherapy. This therapist utilized strategies from Masterson's (1993) psychoanalytic approach to closet

narcissistic personality disorder, and attended to transference themes, unconscious conflict, and defenses of more traditional psychodynamic therapy.

The overall goal of treatment was to help Edward develop his “real self.” More specifically, Edward would ideally be able to tolerate negative affects, maintain his self-esteem by pursuing genuine goals and interests, develop a capacity to empathize with others, and form a more realistic sense of self (Masterson, 1993). The outcome of such would decrease his depressive symptoms, ruminations over his neurological functioning, and sexual masochism.

During the intake assessment, Edward stated that throughout his childhood, he was “terrified and ashamed to tell anyone how he felt” and as a result he “internalized anger and a hatred for humans.” Thus, it was expected that Edward would commence treatment by avoiding his feelings and being extremely wary of the therapist. As such, the beginning part of treatment focused on establishing trust and a sense of safety. Edward repeatedly tested whether I would abandon or humiliate him before he felt comfortable enough to reveal his inner emotions. During the first few months of treatment, Edward focused on his perceived neuropsychological problems and his masochistic sexual behaviors. Edward pulled for me to devalue him and his beliefs as he provided all the results of his past neuropsychological tests that failed to reveal a cognitive issue. He also elaborately described his masochistic sexual encounters, which likely elicited the simultaneous feelings of shame and pleasure that Edward endures when engaging in sexual masochism. Moreover, Edward actively attempted to play out masochistic fantasies early in treatment, and most likely expected me to be a dominant object that forced his masochistic surrender (like his mother). Accordingly, I often asked Edward how he hoped I would respond when he discussed his sexual engagements and his cognitive concerns. As it was still early in treatment, Edward’s avoidance of such questions confirmed that he was not yet ready to explore the therapeutic relationship.

Several months into treatment, Edward arrived for his session very upset and fearing that he might physically harm someone. This therapist decided that it was necessary to call in a supervisor to aid in undergoing a homicidal risk assessment. After the assessment, I talked with Edward about my decision and encouraged him to discuss his related feelings. This session marked a crucial turning point for Edward because, for the first time, he was able to cry in front of me. He told me that he became emotional because he was finally convinced that I truly cared about him. When I inquired about what happened that ultimately convinced him, he evidenced a blurring of boundaries between self and other; Edward perceived that I, too, had become tearful in response to his distress. Although Edward was aware of our physical separation, he would often imagine that my thoughts, feelings, and experiences were the same as his.

Once Edward was able to begin disclosing his feelings, his fantasy of fusion with the therapist became more pronounced. When treatment began, there were rarely any moments when Edward was not speaking, and if I tried to interject, he would often talk over me. Later on, Edward began to demonstrate an interest in hearing what I had to say. He also seemed concerned with learning more about me personally and attempted to draw similarities between us. For example, Edward declared that he was partially Jewish (as he determined that I am Jewish based on my last name) and expressed the belief that the therapist also knew what it was like to feel different from everyone else (in reference to his “unique” brain issues). In addition, Edward began telling me that I was the “most professional and empathic” therapist and that I had “no flaws.” It was also around this time that Edward started looking for a job. Edward’s idealization of me and his sense of our fusion seemed to have resulted in the ego inflation he needed to begin taking steps toward autonomy. However, when Edward attained a job after being unemployed for a year and a half, he presented at the following session with notable depressive affect. This was a common pattern for Edward, which most likely stemmed from the internalization of his mother’s reactions to any attempts at separation or self-assertiveness. After making moves toward independence, Edward feels split (e.g., shame, humiliation, envy, and rage) and copes by presenting the false self that

was pleasing to his mother (e.g., hides grandiosity, devalues self, and idealizes object). Edward's false self is activated whenever he is talking about his perceived neurological impairments, his "inadequacy," his inability to be "omnipotent," and his "pathetic sexual urges." During these periods, Edward would also compare himself unfavorably with me and insist on my "superiority." It was so important for Edward to idealize me and maintain fusion that he would often take the blame for something that was clearly my fault (e.g., spending the majority of a session encouraging him to explore a specific area, while leaving him with no time to discuss something that he felt was more pressing).

Eventually, I began guiding Edward toward an awareness of his tendency to become depressed and self-disparaging after acting autonomously. Edward explained that he feared I would think he has "some sort of complex, is an idiot, and is just trying to overcompensate" if he were to express satisfaction related to any sort of achievement. I pointed out to Edward that he associated self-assertiveness with being shamed and devalued by others. I then encouraged him to consider the origins of this pattern by examining his early relationship with his mother. Edward discussed how his mother would become angry and insult him whenever he tried out new activities and worked to improve his skills in a particular area. For example, when his mother watched him play sports or helped him with his math homework, she would publicly humiliate or criticize him if he made a mistake. Of note, during this time, I noticed that Edward would tell me directly when I made a statement he did not necessarily agree with, as opposed to earlier in treatment when differences in our thinking caused him to feel split.

Edward's openness and insight continued to increase as he started revealing the concealed grandiosity of his real self. Edward admitted to holding a hidden notion that he is an "unsculptured genius." I inquired about the contradiction between thinking he is a genius and viewing himself as neurologically impaired. His response to this question confirmed that his perceived cognitive problem serves as a defense against pursuing his educational goals, separating from the object and challenging his fantasized omnipotence. Edward stated that if he tried to accomplish his goals and "failed," the pain of discovering he is not a genius would be intolerable—This was clearly a consequence of the mirroring Edward was denied by his mother when he experienced the pain and setbacks of separation-individuation. He also pointed out that if he did ultimately discover that there was something wrong with his brain, he would lose all motivation for life.

During the next several sessions, discussions focused on Edward's previous intimate relationships and especially his most recent love interest (that prompted the depression). Edward informed me that even though the woman is married, he was able to visit her multiple times and had sexual relations with her. Edward admitted to knowing all along that she was married, but still making preparations to marry her and move to her city. He also mentioned that she had no idea who he really was because he had lied to her about what he does for a living. Whenever I asked Edward why he thought they could potentially get married, Edward was never able to provide a logical explanation. Instead, he would answer, "I was blind and in denial." Edward also seemed to understand that he found himself attracted to her and fantasized about "merging" with her because she possessed qualities that he wished he had. In general, when Edward was not under significant distress, he typically evidenced some insight into his defenses. This insight was used subsequently in treatment when addressing Edward's erotic transference.

Over time, Edward developed an erotic transference and was encouraged to discuss this experience with the therapist. Edward explained that he was in love with this therapist in the same way he was in love with the aforementioned woman. Edward was encouraged to draw on what he knew had attracted him to his previous lover to understand what might similarly be attracting him to the therapist. As Edward became very anxious and overwhelmed when speaking of his positive feelings toward me, it was difficult for him to think coherently and access his insight. However, Edward noted that both women were younger than him and attaining a graduate

education. He further acknowledged that **when he was involved with the woman, he no longer felt ashamed about his unachieved goals.** Over a number of sessions, I guided him in exploring his intense and debilitating focus on his unachieved goals and perceived neurological impairments upon separation from his previous lover. Such discussions effectively provided a bridge into a conversation about how termination might incite comparable symptoms unless he maintained previously learned insight.

## 8 Complicating Factors

At the start of treatment, Edward was informed that he would be transferred to a new therapist when this therapist reached the end of her 1-year rotation. Soon after the therapeutic alliance was established, Edward expressed his concerns about ending treatment with this therapist. **Although the treatment aims to strengthen the real self and decrease narcissistic vulnerability, the patient will still remain vulnerable to separation distress. Despite making several gains in therapy, it was evident that Edward still sought an idealized female to regulate his self-esteem.** Given that separation from an idealized female had resulted in his most recent major depressive episode, it was essential that processing of termination began early on to prevent a relapse of depressive symptoms. During this time, treatment focused on Edward's increased self-assertiveness and tolerance of negative affects so that he could utilize these gains to bolster his self-esteem upon separation from the therapist. In addition, the potential impact that termination might have on his self-esteem was directly explored. As Edward was interested in further treatment, he was immediately transferred to a new therapist, which would ideally decrease the likelihood of a significant depressive reaction.

## 9 Follow-Up

With informed consent, this therapist consulted with the client's new therapist regarding the treatment approach that was used and this therapist's concerns about a relapse of depressive symptoms. After 1 month of treatment with his new therapist, she reported that he had explored his feelings related to ending treatment with his prior therapist and had not regressed into a depressive state. She mentioned that he had begun to talk about his perceived brain problems but then stopped himself and acknowledged that he should be focusing on his feelings instead.

## 10 Treatment Implications of the Case

Based on Edward's self-report, and through comparison of his presentation at intake with his current condition, several positive outcomes can be noted. When Edward initially began therapy, he would attack the self if he felt misunderstood by the therapist. With time, Edward was able to directly express to the therapist how he felt when he did not agree with something she said, which is indicative of his decreased vulnerability to narcissistic injury and increased tolerance of imperfect mirroring. In addition, Edward reported that he was beginning to feel uncomfortable when engaging in masochistic sexual activities. He explained that in the past, it was easy for him to view the women as simply serving to meet his sexual needs, but he now felt more of a "human connection" to the women, which is evidence of his improved capacity for empathy. Reflective of his increased willingness to become self-assertive, Edward has maintained a full-time job working for a phone company. Edward began therapy unemployed and during his initial interview, Edward expressed the belief that he could only ever attain work that was janitorial or "intolerable." Furthermore, Edward appears to be pursuing genuine self-interests rather than disappointments, as he reported engaging in more creative activities such as "blogging" and has

discussed potentially making a book out of his blogs. Edward reported at intake that, given the lack of empathy he experienced throughout his life, he was “terrified and ashamed to tell anyone how he felt” and therefore “internalized anger and a hatred for humans.” Through a combination of therapeutic neutrality, discussion of Edward’s relational patterns within the hear-and-now transference, confrontation, and guided insight, he consequently experiences less fear of and shame when discussing his feelings. He also has released his internalized aggression (because his interest in sexual masochism has decreased), is less susceptible to narcissistic injury, and has developed greater insight into his symptoms.

## II Recommendations to Clinicians and Students

An awareness of the Depressed/Depleted subtype of narcissism may decrease the incidences in which clinicians feel “stuck” when working with a certain patient. **As the Depressed/Depleted narcissist can present similar to the borderline patient,** it can be helpful to delve deeper into the individual’s history to determine **what the patient is specifically seeking from objects** prior to reaching a differential diagnosis. Moreover, acknowledging the patient’s defenses and object relations and considering them in light of the therapeutic relationship can serve to enhance interventions, prevent against premature termination, and provide the client with a new relational experience.

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