Articles

OVERT AND COVERT NARCISSISM: TURNING POINTS AND MUTATIVE ELEMENTS IN TWO PSYCHOTHERAPIES

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ABSTRACT Two patients, one with an overt and the other with a covert narcissistic disorder, are followed through five years of psychoanalytic psychotherapy. A number of important turning points in the therapies are closely evaluated in order to discover possible mutative elements. Special attention is paid to the patients' self-sufficiency. The attachment process to the therapist and the patients' gradual acceptance of healthy dependency are described. The theoretical framework is selfpsychological.

Introduction

It is not true that the problems pertaining to narcissism necessarily manifest themselves in the same way in every single case. In some cases, the point of departure is overt narcissism, though other forms may also qualify as narcissistic disorders where the dynamics are not visible on the surface. In spite of widely differing clinical points of departure, one may assume that the patients undergoing therapy will have to go through the same phases and turning points. I have had two patients in psychoanalytic psychotherapy where their narcissistic problems were initially expressed as clinically different. As I got to know them better, it struck me that they had a *common psychodynamic problem area*: the regulation of their self-esteem. The sole basic problem common to both found different disguises and different solutions in both these patients. The narcissistic problems revealed themselves in one patient in an extrovert form and in the other patient in an introvert form. This had implications for the treatment approach which was used (selfpsychological). Both patients had approximately five years of intensive psychotherapy with two weekly sessions. This article will throw light upon the process which was instrumental in bringing about a reduction in their *vulnerability*. Partly there was a gradual progression in the process and partly there were distinct *turning points* in the treatment, where important awareness was gained, thus initiating psychological maturation. These turning

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points were subjected to a thorough analysis in order to identify possible *mutative elements* in the therapies. The definition of turning point here is a sequence in the course of the therapy where lasting changes in the patient's regulation of his/her self-esteem are brought about, resulting in new patterns of interaction in the therapy. The patient now experiences himself/herself and/or the therapist in a novel way. The main focus of the article will be on the patient–therapist relationship.

Narcissism and the Regulation of Self-Esteem

Sigmund Freud[1] had already explored the concept of narcissism in 1914. Freud considered that in narcissism the libido was directed inwardly towards the self and not towards the object, as a flight from the oedipal conflict. The result was a self-absorbed, self-sufficient position. Through the interpretation of this defence, the libido was expected to be turned away from the self and towards the therapist. Heinz Kohut's[2] point of departure was his clinical experience with particularly vulnerable and easily offended patients, where standard analytical technique within an ego-psychological framework did not prove a success. He emphasized empathy as a tool in psychoanalysis: to immerse oneself in the subjective perspective of the other and, by doing so, to understand the inner world of the other, the other's self. Kohut's concept of self is an experiential, emotional core of owning oneself, of one's own origin, and a junction of thoughts, feelings and actions. In order to maintain this feeling of self, the individual has a need for selfobjects – objects which are used in the service of the self, or are experienced as a part of the self. The individual develops selfobject transferences in order to satisfy basic narcissistic needs – the need for an idealized other and the need for a confirmation of one's own importance. These needs will manifest themselves in the transference as idealizing and mirroring transferences and are extremely vulnerable. When the transferences are interpreted, the transferences have a tendency to go underground. According to Kohut, they should therefore not be interpreted but rather left to develop. A break in the transference, however, should be interpreted. Twinship-transference or alter ego is a third type of selfobject transference where resemblance to someone or something is sought by the individual in order to get a confirmation of him/herself.[3]

Overt and Covert Narcissism

Narcissistic personality disorders are described in DSM-IV,[4] characterized by a pathological self-centredness which manifests itself in exhibitionism, grandiosity, lack of concern and a discrepancy between ambition and ability (included in the DSM diagnostic system for the first time in the third edition in 1980). However, several authors have pointed to the fact that there exists an alternative presentation of narcissistic pathology which, although different on the surface, has similar psychodynamics. Kohut and Wolf[5] describe a

type of individual who are unable to enjoy success in their lives in a healthy way:

> Since these people are subject to being flooded by unrealistic, archaic greatness fantasies which produce painful tension and anxiety, they will try to avoid situations in which they could become the centre of the attention. (p. 419)

Cooper,[6] Masterson,[7] Akhtar and Thomson,[8] Gabbard,[9] Gersten,[10] Wink,[11] Cooper and Ronningstam[12] and Cooper[13] all suggest that there are two subgroups of narcissistic personality disorder: one, extrovert, which is described in DSM, and one timid, introvert, inhibited type where the narcissism is played out in fantasy. Cooper and Ronningstam[14] say this about the shy narcissistic individuals:

> These individuals carry on most of their narcissistic activity in fantasy ... too inhibited to expose their fantasies to public view. Their self-presentation is likely to be shy and unassuming and may appear deeply empathic, as others mistake their shy, preoccupied wish to be noticed as genuine interest in the other person. They are, however, incapable of maintaining enduring personal relationships, secretly denigrate and are envious of those close to them, and are unable to provide self-reward for their sometimes considerable accomplishments. They respond only to external praise, and that often only briefly as they feel themselves to be fraudulent ... These patients have inner guilt and emptiness over the sense of the shallowness of their relationships, and damage their interpersonal relationships by the eventual revelation of the lack of their concern for others. (pp. 92–93)

Karterud[15] refers to the classification of self-pathology in Kohut's book *The Restoration of the Self*. According to Karterud, Kohut's 'narcissistic behaviour disorder' corresponds roughly to cluster B personality disorder in DSM-III-R (the dramatic, extrovert, impulse-ridden), while Kohut's 'narcissistic personality disorder' tallies with cluster C in DSM-III-R (the more introvert, inhibited and anxious). Here there is consistency between DSM-III-R and DSM-IV which I refer to otherwise. Karterud says further about Kohut's classification:

> The narcissistic behaviour disorders differ thus from the personality disorders purely quantitatively by virtue of *more comprehensive pathology*.... The narcissistic behaviour disorders are burdened with both archaic grandiose-exhibitionistic needs, archaic longings for merging and a lack of stable directional inner structures.... In comparison, the narcissistic personality disorders have a better developed idealizing self. The capacity for drive neutralization is greater, and there is less identity disturbance (norms and values). But the archaic grandiose-exhibitionistic needs are for the most part repressed (horizontal split), draining the individual of creative energy and independent activities. However, the repression is fragile. It is always in danger of breaking down. Anxiety attacks and depressions lie in wait. The most important consoling and narcissistically stabilizing factor is closeness to an idealized selfobject. (pp. 118–120)

Summing up, one may say that Kohut's narcissistic behaviour disorder is in conformity with the overt narcissism described in DSM-IV, while Kohut's narcissistic personality disorder is in accordance with the shy, covert narcissism.

Clinical Presentation

Both patients sought treatment for depressive symptoms and low self-esteem. They did not fulfill the criteria for narcissistic personality disorder according to DSM-IV. Mrs A had, according to my observations, axis I diagnosis social phobia and dysthymia. On axis II she had traits of narcissistic personality disorder in the form of *lack of empathy*. She also had a fully developed *avoidant* personality disorder. Mr B had axis I diagnosis depressive episode (6 of 8 criteria), and on axis II no fully developed personality disorder, but he had traits of narcissistic personality disorder in the form of *open grandiosity and lack of empathy*. He also had traits of *dependent* personality disorder, i.e. problems with making decisions without the support from others. Subjectively they had depressive symptoms and low self-esteem. According to DSM-IV they both also had traits of narcissistic personality disorder and depressive illness.

Mrs A

She was in her early 30s when she came to see me. A somewhat tense woman, bodily and verbally inhibited, grey and anonymous. She had a permanent job and a son in kindergarten.

Initial phase: shyness was prominent She was instructed to say whatever came to her mind. She wanted to be clever, to say the right things. A strong anxiety characterized her the first two and a half years of treatment. She was extremely cautious. The sessions reflected a dull and grey life in which she denied herself the good things in life. She was emotionally distant in the sessions, and felt generally disregarded in her life. She hid herself on the couch where she would not have to meet my eyes. As a paradox to her experience of a hostile world out there, there emerged a picture of her as a person who wanted to cope on her own, alone, pseudo-autonomously. She wanted to use me as an instrument for relieving her of her agony in a rather technical way. But she also pictured me as being critical, hostile, demanding, someone who would be mocking her if she really let me get to know her.

Turning point: revelation of shame (of lacking empathy) A turning point came after two years of therapy. For the first time she managed to talk about a difficult event that had taken place several years earlier. Her son had lost weight and been in bad shape. She denied her son's problems to herself until she was advised to seek medical help. It turned out that he suffered from diabetes, and he had probably gone through periods of dangerously high levels of blood sugar. Only when her son was hospitalized did she understand that she had neglected him. She felt ashamed for not being a better mother. She bore her self-reproach in loneliness. By telling me about it she started to leave the lonely road.

What preceded the turning point? Our relation was tense. She demanded

of me that I make her feel secure. When I did not comply, she became irritated. She saw me as critical and hostile and this hindered her in receiving human warmth and care. She experienced my interpretations as invasions and wanted to leave. Her *self-esteem regulation* turned destructive. She thought of herself as *independent* but, when faced with misfortune or criticism, she devalued herself. She therefore felt inferior, egocentric and mean whenever she felt the need to be cared for. She could then drop sessions. As soon as she had reestablished her *pseudo-autonomous* position she felt better. I pointed out to her that she did not care for herself, that she hadn't learned it. I tried not to reciprocate her rejection, but to understand it as her fear of closeness.

At this turning point she showed a shameful side of herself. The fact that she didn't see her child's needs she considered as a basic defect in herself, that she lacked empathy. I met her with acceptance: 'Your childhood hardships make this understandable'.

After the turning point the patient focused more on herself, less on her image of the cruel external world. She showed her dependency in the practical details of everyday life, her vulnerability. Her self-esteem regulation became more constructive; she was less self-critical, more self-soothing. Our relation was now less tense. She was now able to accept support and interpretations.

In the period following the turning point, innumerable sessions were used to throw light upon the ways in which she attributed hostile attitudes to others. Her social anxiety diminished. Again she wanted to leave. She felt increasingly vulnerable. There was a growing feeling of relatedness and a conscious need for human closeness and warmth.

Another turning point: acknowledgment of her covert narcissism and the shame connected to it A year after the first turning point she became increasingly devaluing towards her colleagues and friends. Parallel to this she felt she had to control herself. Certain aspects of her internal world could not be disclosed. A question began to form inside me and, eventually, I asked her: 'Do you feel you are better than other people?' This intervention brought into the open her feeling of being ashamed of considering herself superior to others. I confirmed that she needed to raise herself above others because she felt inferior.

What preceded this turning point? She began to feel increasingly attached to me and thereby also ambivalent. She felt a need for human closeness, and also felt vulnerable and dependent. Then again she would shift to the pseudo-autonomous position. She would ask for increased session length or frequency, followed by dropping her sessions. Her self-esteem regulation became more self-nurturing. Her increasing capacity for expressing feelings of vulnerability was accompanied by a devaluation of others. I interpreted her devaluation as a sign of a covert grandiosity.

At the turning point she accepted my interpretation of her grandiosity. She was ashamed of herself for devaluing others. I interpreted her grandiosity as a necessary defence against unendurable self-contempt.

After the turning point she was able to admit my importance in her own life. She didn't reproach herself as before, and had therefore internalized a self-soothing structure. A wish to quit therapy accompanied her growing attachment. She seemed more vital.

Mr B

He engaged me strongly from the very start. He was in a crisis. He told me about his mother wanting to destroy him. The crisis resolved quickly when he started seeing me.

Initial phase: distance through words His language was rich, intellectual and somewhat pompous and he loved to show off. But, I wondered, who was behind those words? I asked him and he said that he felt empty, without a core. This corresponded poorly with how I intuitively experienced him. I said to him: 'You must have hidden yourself deeply inside yourself'.

Relational problems By and by it became evident to him that he had difficulty relating emotionally to others, including myself. It had to do with his character, some inner defect. He became self-critical and depressed. He was often overwhelmed by tiredness.

Turning point: depressive crisis when confronted with his own weakness and indecisiveness After a year and a half in treatment he had the opportunity to move to a better apartment, but he could not decide what to do. He saw clearly that he lacked something inside himself which could give him advice and allow him to discuss matters at hand. He was totally dependent on the external world. This made him feel weak, which in turn triggered a depressive crisis with massive self-retaliation. He nearly killed himself.

What preceded the turning point? He had always had a close relationship to his mother whom he experienced as invading him. He had several times been abandoned by his mother and father. He withdrew in order to protect himself from his mother. He compensated his low self-esteem with a shallow, impressive verbality. He experienced himself as being without a core and overburdened. He idealized his corelessness as a true identity of our time but he had not integrated the emotional experiences of his lost childhood. My interventions were supporting and confrontational. I could say: 'It must be difficult not to be able to seek advice and receive answers inside yourself, but it can be understood in the light of your personal history.' This frustrating stance of mine made the patient well aware that he lacked the ability to make independent choices, i.e. his self-defect. His grandiose, intellectualizing defence broke down and could no longer prevent him from feeling defective, inferior.

At the turning point, the patient experienced himself as totally dependent on the external world. This led to a massive attack on the self, a depressive self-retaliation. He had not internalized a self-soothing agent. Aggressive feelings overwhelmed him, and threatened him with fragmentation. The fragile self was unable to cope with the sum of demands from the external world and the retaliating ideal self. I endured his destructiveness, without offering any advice. I tried to be calming.

Patient: 'You've got a patient with interminable problems.'
I said: 'I can live with that.'

He eventually broke down, the pressure of internal and external demands becoming too heavy to bear. He saw suicide as a way of attaining peace.

After the turning point, the patient was emotionally unstable. On the one hand, he felt empty and lonely accusing himself of being weak and, on the other hand, he wished and demanded to be advised and supported. He gradually acknowledged emotionally his relational difficulties. I continued to focus on our relation and the degree of closeness.

Twinship. His self-accusations decreased the following months and our relation became closer. We were in tune with each other and had fun. A kind of a dance or a game. He now used his language differently; as a communication and to get emotionally close, not as before as a defence. He now experienced a growing capacity for internal dialogue.

New choice. One year after having made his first choice, he was faced with another. Now he took good time to elaborate on advantages and disadvantages, and had only a mild depressive reaction. After this choice he became more vital and accessible during sessions.

Another turning point: depression when feeling lonely In a session early in the fifth year of treatment he started to talk about how he remembered himself as a child. He had told me the same story many times before without any affect. He said: 'I was a lively child with a lot of anger. I was told later that at a certain point I became quiet.' As he talked he became quiet, sad, on the verge of tears. He was flooded by the emotions of his difficult childhood. He felt sad about having lost himself then, for not having found any space for himself.

What preceded the turning point? There was a short break due to a holiday. After this break his themes were about parents, lacking care from parents, being abandoned by parents. His early separation traumas were reactivated by the break in the therapy. I was deeply touched by his account of how his parents had abandoned him, and said:

'Having a sick mother is like a Holocaust for a child!'

At the turning point the patient let his feelings surface, but without becoming chaotic. He was stronger now and able to mourn without fragmenting. He mourned his lost childhood. We shared this emotional experience. The

contents of his sad feelings were the loss of his parents and not self-contempt as it had been earlier in the treatment. He was empathic with himself.

After the turning point there was a period of several months when he was rather more quiet, thoughtful.

Discussion

The two patients described started off with depressive symptoms in connection with low self-esteem. In the middle of the process I didn't recognize the turning points as such when they came along. Later on I have been able to evaluate the process through my notes, self-reflection and supervision. By following these patients for a long time in therapy I was able to see how they resolved old problems in new ways; this is the strength of long-term therapy. It also opens up for identifying mutative elements. Now, seen in retrospect, what is it that characterizes the turning points?

At Mrs A's *first turning point* she was externalizing, critical and self-sufficient. This was evident from her refusal to share her suffering. She started leaving this pseudo-autonomous position when she showed me that she was ashamed of herself. Her longing for human warmth had grown; she had begun to attach herself after two years in therapy. I had been there, listening and trying to understand her. This was a positive new relational experience, and she now dared expose her vulnerability without fearing rejection to the same degree as before. *At the second turning point* the patient changed from being devaluating with covert grandiose fantasies to revealing her grandiosity upon my interpretation of it. She accepted my interpretation of her shame-ridden covert narcissism as a necessary defence against her vulnerability. When this narcissistic defence was made conscious she was able to accept her need for others, and not be self-sufficient as before.

The extrovert Mr B was dependent. *At the first turning point*, when unable to make choices his grandiose self broke down, and he became depressed and self-accusing. The therapy process enabled him to identify with caring provided by me and to integrate them as a guiding, self-soothing structure. He could only do this after having abandoned the pseudo-autonomous position. *At the second turning point* he was attached to me. Acknowledging his dependence enabled him to mourn.

In both therapies the patients had to go through nearly the same sequences in regard to giving up their self-sufficiency and in regard to the attachment process. After initially keeping an emotional distance they both got closer. At the first turning point they revealed their shame which was due to their self-defect (lack of empathy, lacking ability to make choices). They implicitly gave up some of their grandiosity by admitting and showing their weakness and thereby gave the human relationship a stronger position through attachment. The core of the depressive symptoms was a feeling of being defective and worthless, which in turn triggered self-criticism. After

the first turning point the patients entered a period of self-defect repair. I have earlier referred to Karterud. His discussion of Kohut's classification of self-pathology may in this connection throw light upon the various processes in the therapies. According to Karterud,[16] introverted persons have less comprehensive problems with less identity disturbances, but when there is introversion the repression of archaic grandiose-exhibitionistic needs is unstable (Kohut's narcissistic personality disorder). Mrs A had covert narcissistic problems, she had an avoidant personality disorder. She worked through her self-defect by continuing to reveal and work through her vulnerability, by being open to acceptance of who she was and by integrating self-soothing structures. She did not develop a twinship-transference to me. The more extroverted persons, according to Karterud, have a more extensive pathology characterized by archaic grandiose-exhibitionistic needs, archaic longings for merging and a lack of stable directional inner structures (Kohut's narcissistic behaviour disorder). Mr B, with his overt narcissistic problems, entered into a twinship-transference which expressed this archaic longing for merging. By going through this twinship-transference phase, he integrated guiding inner structures which enabled him to make choices.

Towards the end of the therapies both patients accepted more explicitly their need for others. This was expressed in their grief for separations from the therapist and lost relatedness in the past. *The patients had given up their self-sufficient, pseudo-autonomous position, accepted a natural dependency and attached themselves to the therapist.* It was a seeming paradox that, through acknowledging their dependency and attachment to the therapist, they became more independent. Through attachment to the other, it becomes possible to integrate psychic structures. These structures enable the person to live an independent life in coexistence with others. Thus, the mutative elements at the turning points seem to have been the acknowledgment of pseudo-autonomy, dependence and, eventually, attachment to the therapist.

Mr B, who was extroverted and who, according to Karterud, should have a more extensive pathology, attached himself quicker and became closer to me than Mrs A. Mr B made better use of me as a nourishing selfobject and made faster progress in the therapy. Mrs A, who was introverted, was more unwilling to attach herself to me. As mentioned earlier, Cooper and Ronningstam[17] have described the timid narcissistic individuals whose narcissistic activities take place mostly in their fantasy. This was the case for Mrs A. She felt superior to those around her, was envious of them and devalued them. After four years of therapy her grandiose defence was made conscious. It was only then that she was able to renounce her grandiose position and devaluation of me. This made room for a deeper emotional attachment. Even though her pathology was less comprehensive than Mr B's, her introvert, avoidant behaviour made it difficult for her to make use of me as a healing selfobject.

As an alternative to Karterud's model, one may also consider a genetic explanation. Mr B had extroverted parents, Mrs A had rather introverted parents – which may support an explanation of the origins of these types. It is tempting to continue this line of thought as to why these patients have become as they are, but it is beyond the scope of this paper.

Mutative Elements

The therapist's empathic attitude is necessary in order to build up and maintain a stable alliance in the therapy. The patient will then be able to use the therapist as a selfobject which sees, understands and is considerate, thus using the therapist as a self-esteem-regulating and stabilizing factor. According to Kohut,[18] a failure in the selfobject function – for instance, when the therapist cancels a session or is not sufficiently attentive during the session – may lead to transmuting internalization if adequately handled by the therapist. If the alliance is sufficiently strong and the failure not too overwhelming, the patient can take over some of the functions of the therapist. Thus psychic structure is built.

Stolorow, Brandschaft and Atwood[19] have asserted at a later stage that: 'the formation of structure mainly takes place when the tie to the selfobject is intact or about to be reestablished' (p. 24). It is therefore the good novel relational experience which is the healing factor. Optimal response rather than optimal frustration promotes the development of the self. This optimally responding attitude comprises both interpretations and the relational aspect in the relationship to the therapist.[20] Kohut viewed transforming internalization as an important healing mechanism. In the opinion of Stolorow and Atwood, it is the relationship itself which is therapeutic. Even today there are still contrasting viewpoints between traditional self-psychological concepts and the theory of intersubjectivity.[21] In the therapies described I had been absent prior to several of the turning points. This may indicate that, correctly handled, selfobject failure has a positive effect on the therapy and initiates the building of psychic structure. The turning points first emerged after about two years of therapy; this may indicate that a stable relationship is essential for maturation and growth in therapy.

The Character of Depressions

Initially the depressive episodes in both therapies were connected to themes of self-esteem. The patients experienced themselves as inferior and miserable, and blamed themselves for this. In the case of Mr B these self-accusations led to a serious depressive crisis at the first turning point because he felt incapable of making a choice. Mrs A accused herself of being an inadequate person when telling me that she had not been aware of her son's suffering. The depressive episodes changed character in the course of the therapies. In the later part of the therapies the emotional content in the

depressions were feelings of sadness and grief for earlier losses and the thought of losing the therapist.

Through the therapy process the patients' self-criticism connected to their own self-defect had lessened through recognition of their own natural dependency and their attachment to the therapist. The vulnerability related to self-esteem had given way to a vulnerability to loss. Both these particular forms of depression have been described by other authors. Blatt and Zuroff[22] discovered in the literature that self-criticism and dependency are two personality factors which are connected to two different types of depression. Vaglum and Falkum[23] also found a connection between depression and dysfunctional attitudes in the form of self-criticism and dependency. In both the therapies described here the development from self-esteem depression to dependency depression may imply therapeutic progress. One may ask here whether the self-criticism initially expressed was the result of a lack of emotional attachment to another person, since the self-criticism diminished in parallel with the attachment to me.

Have the Patients Improved? Changes in Vulnerability and DSM-IV Diagnosis

Right from the start of the therapy, Mrs A's self-esteem had been low and she was extremely vulnerable to criticism. This was also part of the dynamics of her limited social life – she avoided human contact for fear of being criticized and abandoned. She felt that she was unworthy of love and unlovable. This vulnerability to criticism was reduced in the therapy. This came to light in the therapy room when the patient gradually began to experience me as less critical. Especially after the turning points, the patient became more secure and open. She also functioned better socially because she felt less vulnerable and stronger. She no longer feared being criticized and abandoned. At the start of the therapy she had a diagnosis according to DSM-IV of social phobia and dysthymia, as well as an axis-II-diagnosis of avoidant personality disorder. After three and a half years of therapy she revealed her grandiose fantasies which fulfilled three of the criteria for a narcissistic personality disorder: grandiosity, lacking empathy, devaluing attitudes. After four years of therapy she did not fulfil the criteria for social phobia, dysthymia or avoidant personality disorder; but she did fulfil one of the criteria for avoidant personality disorder (limitation in intimate relationships for fear of being ridiculed or shamed).

At the start of the therapy Mr B had a vulnerability which was concealed by a narcissistic defence and which consisted of an inability in making choices. In the course of therapy he repeatedly encountered situations in his life where he had to make choices and he gradually demonstrated an improvement in this area. His deficiencies decreased over the course of the therapy, from causing total breakdown early on to creating temporary minor

inner anxiety towards the end of the therapy. At the start of the therapy he could be diagnosed as having *depressive episodes* (six out of eight criteria fulfilled) according to DSM-IV, axis I. In the course of the therapy he had several depressive episodes of decreasing intensity and duration. These were linked to psychological events in the course of the therapy. After four years in therapy he did not fulfil the criteria for any type of affective disorder. On axis II he did not have a fully developed personality disorder when starting therapy. He had *traits of dependency* (difficulties with everyday decisions without the support and advice of others, needing others to take responsibility for his life, after break-ups looking quickly for new relationships for support), and *traits of a narcissistic personality disorder* (lack of empathy, grandiosity). After about a year and a half in therapy, according to my observation, he satisfied all criteria for a *dependent personality disorder*, apart from the criterion of permanence; this state lasted for about one year in this patient. This may be seen to signify that in the initial phase of the therapy his narcissistic defence concealed the self-defect which made him dependent. When his narcissistic defence broke down, his dependent functioning came to light and persisted until he was restored through the therapy. After four years in therapy he did not fulfil the criteria for any type of personality disorder.

Conclusion

This article demonstrates that, during long-term psychoanalytic psychotherapy within a selfpsychological frame, there can be a reduction in the vulnerability of patients with narcissistic problems. In the therapies described here, the patient with overt narcissism had underlying dependent traits, while the patient with covert narcissism had avoidant traits. The time frame for the therapies was five years; it took two years before a turning point occurred in both therapies. A sign of improvement was reduced vulnerability, i.e. reduced sensitivity to criticism and greater autonomy. One may assume that both the therapeutic relationship and the interpretations have contributed to the improvement. However, the most important factor has been the acknowledgement by the patients at the turning points of pseudo-autonomy and dependency which laid the foundation for a healing selfobject transference. The change in the character of the depressions in the course of the therapies seems to indicate an improvement. Of the two patients, the patient with overt narcissistic problems was better able to benefit from the therapy than the patient with covert narcissistic problems.

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