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The Almost Untreatable Narcissistic Patient

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Clinical experience in the Personality Disorders Institute at Weill Cornell Medical College suggests that patients with borderline personality organization and a narcissistic personality disorder have a more serious prognosis than all other personality disorders functioning at the borderline level, and that those who in addition present significant antisocial behavior have an even worse prognosis (**Clarkin, Yeomans, and Kernberg 1999**; **Stone 1990**). This negative trend culminates in a group of practically untreatable patients with antisocial personality disorder, who represent the most severe cases of pathological narcissism. There are also patients with severe narcissistic personality disorder, functioning at an overt borderline level with significant antisocial features, but not presenting an antisocial personality disorder proper, who at times respond to treatment, while others do not. These patients are explored here, with a focus on particular psychotherapeutic techniques that have proven helpful, as well as on the limits of these technical approaches.

In order to keep this introductory section reasonably short, a certain categorical style is almost unavoidable. But because this section provides the organizing frame for what follows, I beg the reader's indulgence. The narcissistic personality disorder presents, clinically, at three levels of severity. The mildest cases, who appear "neurotic," usually present indications for psychoanalysis. They typically consult only because of a significant symptom, one that seems so linked to their character pathology that anything but the treatment of their

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personality disorder would seem inadequate. In contrast, other narcissistic patients at this level present symptoms that may be treated without an effort to modify or resolve their narcissistic personality structure. All these patients seem to be functioning very well, in general, though typically they present significant problems in long-term intimate relationships, and in long-term professional or work interactions. A second level of severity reflects the typical narcissistic syndrome, with all the various clinical manifestations to be described below. These patients definitely need treatment for their personality disorder, and here the choice between standard psychoanalytic treatment and psychoanalytic psychotherapy depends on individualized indications and contraindications. At a third level of severity, patients with narcissistic personality disorder function at an overt borderline level: in addition to all the typical manifestations of narcissistic personality disorder, these patients also present a general lack of anxiety tolerance and impulse control, as well as severe reduction in sublimatory functions (that is, in the capacity for productivity or creativity beyond gratification of survival needs). These patients usually show severe and chronic failure in their work and profession, and chronic failure in their efforts to establish or maintain intimate love relations. At this same level of severity, another group of patients do not show overt borderline features but instead present significant antisocial activity, which, prognostically, places them in the same category as those who function on a borderline level.

All of these severely narcissistic patients may respond to a psychoanalytic, transference-focused psychotherapy, unless, for reasons specific to an individual, this approach would seem contraindicated, in which case a more supportive or cognitive-behavioral approach might be the treatment of choice (**Kernberg 1997**; **Levy et al. 2005**). Patients whose antisocial behavior is predominantly passive and parasitic present less of a threat to themselves and to the therapist than do those who present severe suicidal and parasuicidal behavior, or violent attacks against others. Aggression against others or self is typical for antisocial behavior of the aggressive type, particularly when these patients fulfill the criteria for the syndrome of malignant narcissism. That syndrome includes, in addition to the narcissistic personality disorder, severe antisocial behavior, significant paranoid trends, and ego-syntonic aggression

(this last may be directed against the self or against others).

Let us now briefly review the dominant features of the narcissistic personality disorder as typically represented, particularly at the second or intermediate level of severity **(Kernberg 1997)**.

1. Pathology of the self: these patients show excessive self-centeredness, overdependency on admiration from others, prominence of fantasies of success and grandiosity, avoidance of realities that are contrary to their inflated image of themselves, and bouts of insecurity disrupting their sense of grandiosity or specialness.
2. Pathology of the relationship with others: these patients suffer from inordinate envy, both conscious and unconscious. They show greediness and exploitative behavior toward others, entitlement, devaluation of others, and an incapacity to really depend on them (in contrast to needing their admiration). They show a remarkable lack of empathy with others, shallowness in their emotional life, and a lack of capacity for commitment to relationships, goals, or joint purposes with others.
3. Pathology of the superego (conscious and unconscious internalized value systems): at a relatively milder level, patients evince a deficit in their capacity for sadness and mourning; their self-esteem is regulated by severe mood swings rather than by limited, focused self-criticism; they appear to be determined by a "shame" culture rather than by a "guilt" culture; and their values have a childlike quality. More severe superego pathology, in addition to defective mourning, entails chronic antisocial behavior and significant irresponsibility in relationships. A lack of consideration for others precludes any capacity for guilt or remorse for such devaluing behavior. Malignant narcissism, a specific syndrome mentioned earlier, reflects severe superego pathology characterized by the combination of narcissistic personality disorder, antisocial behavior, ego-syntonic aggression (directed against self and/or others), and marked paranoid trends.
4. A basic self state of these patients is a chronic sense of emptiness and boredom, resulting in stimulus hunger and a wish for artificial stimulation of affective response by means of drugs or alcohol that predisposes to substance abuse and dependency.

Patients with narcissistic personality disorder may present typical complications of this disorder, including sexual promiscuity or sexual inhibition, drug dependence and alcoholism, social parasitism, severe (narcissistic type) suicidality and parasuicidality, and, under conditions of severe stress and regression, the possibility of significant paranoid developments and brief psychotic episodes.

General Technical Issues in the Treatment of Narcissistic Personality Disorder

As I have noted, the indications for various psychoanalytic modalities and other forms of treatment depend on severity of the illness and the individual combination of symptoms and character pathology. The general techniques of standard psychoanalysis and psychoanalytic psychotherapy have to be modified or enriched by specific approaches to dealing with narcissistic transference-countertranference binds **(Koenigsberg et al. 2000)**. Without further exploring here the general differences between these modalities of treatment or their respective indications, I will spell out particular issues that typically emerge in the treatment of narcissistic patients and that become especially dominant in encounters with the "almost untreatable narcissistic patients" I will present. These issues require specific technical approaches, drawing from the entire spectrum of psychoanalytically derived treatments, that I will also describe.

A core issue for narcissistic patients is their inability to depend on the therapist, because such dependency is experienced as humiliating. Such fear of dependency, often unconscious, is defended against with attempts to omnipotently control the treatment (**Kernberg 1984**; **Rosenfeld 1987**). Clinically, this takes the form of the patient's efforts at "self-analysis," as opposed to a collaboration with the therapist leading to integration and reflection. These patients treat the therapist as if he were a "vending machine" of interpretations, which they then appropriate as their own, at the same time being chronically disappointed for not receiving enough interpretations, or not the right kind, unconsciously dismissing everything they might learn from him. For this reason, treatment often maintains a "first session" quality over an extended period. Narcissistic patients show themselves as intensely competitive with the therapist, and are suspicious of what they consider his indifferent or exploitative attitude toward them. They cannot conceive the therapist as spontaneously interested and honestly concerned about them; as a result, they evince significant

devaluation and contempt of the therapist.

Narcissistic patients may also show a defensive idealization of the therapist, considering him "the greatest," but such idealization is frail and can rapidly be shattered by devaluation and contempt. It also may be part of omnipotent control befitting their grandiosity, in that these

patients unconsciously attempt to force the therapist to be always convincing and brilliant, but not superior to them, as that would generate envy. They need the therapist to maintain his "brilliance" in order to protect himself from their tendency to devalue him, which acted on would leave them feeling totally lost and abandoned in the treatment.

A major feature of all these manifestations is the patient's conscious and unconscious envy of the therapist, the patient's consistent sense that there can be only one great person in the room, who necessarily will depreciate the other, inferior one. This belief motivates the patient to try to stay on top, though at the risk of feeling abandoned due to loss of the devalued therapist. Envy of the therapist is at the same time an unending source of resentment of what the therapist has to give, and may take many forms. The most important is envy of the therapist's creativity, of the fact that he can creatively understand the patient rather than providing him pat, clichéd answers that can be memorized by the patient. Also, the very capacity of the therapist to invest in a relationship, a capacity the patient knows he lacks himself, is envied. The most important consequence of these conflicts around envy are negative therapeutic reactions: typically, the patient feels worse following a situation in which he clearly acknowledged having been helped. Envious resentment of the therapist may be acted out in a variety of ways, including playing one therapist against another; aggressive pseudoidentification in which the patient plays the therapist's role in a destructive interaction with third parties; and, quite frequently, the patient's constructing a view that he alone is the cause of his progress.

Analysis of the idealized self and idealized object representations that jointly consolidate into the pathological grandiose self of these patients tends gradually to reduce both the grandiosity in the transference and the pseudointegration of that self, and brings into the transference the primitive internalized object relations and the primitive affective investments that attend them. This development shows clinically in the breakthrough of aggressive reactions as part of such primitive object relations, including suicidal and parasuicidal behavior in unconscious identification with powerful hostile objects: the "victory" of these primitive object representations over the therapist may be symbolized by the destruction of the patient's body.

Chronic suicidal tendencies of narcissistic patients have a premeditated, calculated, coldly sadistic quality that differs from the impulsive, "momentarily decided upon" suicidality of ordinary borderline patients

(Kernberg 2001). The projection of persecutory object representations onto the therapist in the form of severe paranoid transferences also may become predominant, as well as a form of narcissistic rage that expresses both a sense of entitlement and envious resentment. "Stealing" from the therapist may take the form of learning his language and applying it to others, or may show itself in the syndrome of perversity, wherein what is received from the therapist as an expression of concern and commitment is malignantly transformed into an expression of aggression toward others. The corruption of superego values may be acted out as antisocial behavior that the patient unconsciously perceives as caused by the therapist's irresponsibility rather than by himself.

Narcissistic entitlement and greedy incorporation of what the patient feels is denied him may take the form of apparently erotic transferences, demands to be loved by the therapist, or even efforts to seduce the therapist as part a general effort to destroy his role. These are severe complications, very different from the erotic transferences of neurotic patients.

When improvement occurs, the severe envy typically diminishes and the capacity for gratitude begins to emerge both in the transference and in extratransferential relations, particularly in the relationship with intimate sexual partners. Envy of the other gender is a dominant unconscious conflict of narcissistic personalities, and a decrease of this envy permits a decrease of unconscious devaluing attitudes toward intimate partners and hence an improved capacity for maintaining love relations. Narcissistic patients may become more tolerant of their feelings of envy without having to act them out, and increased awareness of them allows tendencies toward defensive devaluation to gradually decrease. The development of more mature feelings of guilt and concern over aggressive and exploitative attitudes indicates a consolidation of the superego and a deepening of object relations. At times, however, the now integrated superego is so sadistic as to occasion severe depression in these patients just as their character pathology begins to improve.

Under optimal conditions, patients who for an extended period have experienced predominantly psychopathic transferences (a conviction of the therapist's dishonesty, or conscious dishonesty and deception on the patient's part) may shift into paranoid

transferences against which the psychopathic transferences had been a defense. Later on, those paranoid transferences (related to the projection of persecutory object representations and superego precursors onto the therapist) may

themselves shift into depressive transferences, as the patient becomes able to tolerate ambivalent feelings and to recognize his experience of both intensely positive and intensely negative feelings toward the same object **(Kernberg 1992)**.

Perhaps the transference development most difficult to manage is that of patients with extremely intense aggression that may present itself as almost uncontrollable suicidal and parasuicidal behavior outside the sessions, and as chronic sadomasochistic transferences in the sessions. In the latter case, the patient sadistically attacks the therapist over an extended period, clearly attempting to provoke a response in kind. Should the therapist oblige, the patient then accuses the therapist of being aggressive and destructive. In all of this, the patient experiences himself as the therapist's helpless victim. This development of a secondary masochistic relation to the therapist may be followed, in turn, by self-directed aggression in which the patient accuses himself exaggeratedly of his "badness," only to revert eventually to sadistic behavior toward the therapist, thus reinitiating the cycle. Here the technical approach involves pointing out to the patient these patterns of experiencing self and other as either aggressor or victim in the transference, with frequent role reversals.

Another manifestation of severe aggression in the transference is the syndrome of arrogance, quite frequently present in narcissistic personalities functioning at an overt borderline level: a combination of intense arrogant behavior, extreme curiosity about the therapist and his life but little about himself, and "pseudo-stupidity," an inability to accept any logical, rational argument **(Bion 1967)**. The main defensive purpose of this syndrome is to protect the patient against any awareness of the intense aggression that controls him. Aggressive affect is expressed in behavior, rather than in an affectively marked representational process.

While these transference developments may emerge in any treatment modality, the advantage of psychodynamic psychotherapies and psychoanalysis, where indicated, is that they may permit resolution of these transference manifestations by means of the interpretive focus. In contrast, supportive and cognitive-behavioral treatments may control and reduce the most severe effects of these transference developments on the relationship with the therapist, but their continued unconscious control of the patient's life continues to be a major problem. Supportive and cognitive-behavioral approaches may reduce, by educational means

combined with a general supportive attitude, the inappropriate nature of the patient's interactions at work or in a profession. However, in my experience, work at this level is not sufficient to modify the incapacity of these patients to establish significant love relations in depth, and to maintain gratifying intimate relations in general. And, not infrequently, the difficult transference developments described above may undermine supportive or cognitive-behavioral approaches. Therefore, when it seems reasonable to believe that the patient may tolerate an analytic approach, regardless of the severity of the symptomatology, that indication is usually prognostically positive. Nonetheless, as we shall see in the next section, such an analytic approach has definite limits.

There are references in the psychoanalytic literature, particularly within the Kleinian tradition, that indicate therapeutic success using unmodified analytic approaches with severely ill narcissistic patients (**Bion 1967**; **Spillius 1988**; **Spillius and Feldman 1989**; **Steiner 1993**). The work of Steiner, particularly, clearly refers to the analysis of narcissistic patients, whom he designates as presenting a "pathological organization"; **Hinshelwood (1994)** points to the use of this term in the Kleinian literature in reference to "inaccessible personalities." One problem, however, is that the overall description of such patients in that literature usually lacks sufficiently detailed information about their general symptomatology and personality characteristics, making it difficult to compare them to the patients referred to in our work at Cornell. In addition, the subtle and convincing descriptions in the Kleinian literature of particular transference interpretations with these patients conveys a sense of their effectiveness that leaves open the broader question of the treatment's long-range effectiveness, and so does not allow us to specify indications and contraindications.

We have been strongly influenced by the clinical insights of the Kleinian school, but wonder whether their clinical excerpts might not be taken primarily from successful cases, with little attention to unaccepted, unsuccessful, or interrupted ones. Of course, most analysts, of any orientation, tend to mention only in private their unsuccessful cases, or cases they have rejected as too problematic. In this paper, in contrast, I focus specifically on the most severe cases within the narcissistic spectrum, in the context of a careful evaluation of symptoms, personality, and long-range developments, and the experience of both success and failure with them.

The Typical Presentation of "impossible" Patients

Negative prognostic features usually become evident during the initial evaluation of patients, but we are all familiar with cases in which, despite careful history taking and assessment, important information emerges only after treatment has begun, altering our initial diagnostic and prognostic impressions. There are, however, typical manifestations, identifiable in the initial evaluation, of what may eventually prove almost insurmountable obstacles to treatment. The following cases reflect such frequent danger signals.

Chronic Work Failure despite High Educational Background and Capacity

These are patients who for many years have worked below their level of training or capacity, and often drift into a "disabled" status so that they must be cared for by their families (if they are wealthy) or by the public social support system. Such a chronic dependency on the family or on a social support system represents a major secondary gain of illness, one of the principal causes of treatment failure. In the United States, at least, these patients are high consumers of therapeutic and social services; however, were they to get well, they would no longer qualify for the supports that maintain their existence. These patients come to treatment, consciously or unconsciously, not because they are interested in improvement, but in order to demonstrate to the social system their incapacity to improve, and therefore their need for ongoing support. Because they are usually required to be in some kind of treatment in order to get supportive housing, SSI, SSD, and other benefits, they go from program to program, therapist to therapist. Michael Stone, a senior member of our Personality Disorders Institute at Cornell, has concluded that, for practical purposes, if a patient were able to earn by working at least 1.5 times the amount he is receiving from social support systems, there may be a chance that eventually he will be motivated to work again. Otherwise, the secondary gain of illness may well carry the day **(Stone 1990)**.

The underlying psychodynamics of this situation vary from case to case. There are patients who would be willing to work if they became immediately the chief executive officer of a major industry or a leader in their profession. The need to start out in an "inferior" beginner's

position they regard as an intolerable humiliation. There are many patients who prefer to live on welfare rather than undergo the "humiliation" of working in a subordinate position. There are cases in whose dynamics an unconscious rage at being expected to take care of oneself is the dominant feature. These are patients who feel that, given the severe frustrations or trauma they have endured, they deserve special treatment in life; to become active on their own behalf would mean to renounce that vengeful expectation.

Consciously, these dynamics may show only as the emergence of severe symptoms of anxiety or even depression whenever these patients attempt to work. Often these are patients who have learned by heart all the symptoms of anxiety disorders, who claim on the one hand that they have a chronic anxiety disorder for which they must be in an ongoing psychopharmocological treatment and, on the other, that even with the use of medication, the anxiety becomes uncontrollable whenever they try to work. This specific emergence of severe anxiety when any work possibilities are contemplated is particularly ominous. There are still other patients in whose pathology antisocial features dominate; as long as they can exploit relatives or society, it seems foolish to them, and therefore humiliating, to work.

This condition of work failure may merge with grandiose fantasies of capacities and success that remain unchallenged as long as the patient does not become part of the work force: the rationalization of this pattern of social parasitism may include a fantasized profession or talent the patient has that no one has recognized as yet: the unknown painter, the inhibited author, the revolutionary musician. Often such a patient is perfectly willing to enter treatment as long as someone else pays for it, and will abandon it the day payment is no longer available, even if the treatment could continue were the patient willing and able to take on remunerated employment.

Case 1. The patient, a man in his late forties from a rather aristocratic family in Great Britain, had studied at prominent universities in the United States and gone on to a career in business. There, despite excellent recommendations and social connections, he failed to progress owing to his haughty, demanding, and subtly irresponsible behavior. Having been bypassed for important promotions, he would change from one firm to another, eventually creating for himself the reputation of someone who cannot be relied on in a leadership position. He married a businesswoman he had met on one of his jobs, originally in a

position subordinate to his; however, through her intelligence and hard work she had managed to be promoted to ever more senior positions.

His wife eventually surpassed him in the world of business, whereupon he withdrew from work completely. He started to drink, became depressed, and developed hypochondriacal symptoms that motivated his seeking treatment first with internists, after which he was referred for psychiatric treatment. After brief psychotherapeutic encounters with various psychiatrists, all of whom he dismissed as rather useless, he entered psychoanalysis. At that point he had not been working for several years. He was living on a rapidly shrinking inheritance and the financially privileged situation of his wife, while resenting bitterly his dependency on her, which he acted out by having brief relationships with a series of women.

He presented a rather typical narcissistic personality disorder, and his transference to his analyst rapidly evolved into alternating manifestations of intense envy and devaluation. He perceived his analyst as a successful "cutthroat" businessman whom he hated, an attitude similar to the dominant feelings he harbored toward his wife and, at a deeper level, his domineering and self-centered "aristocratic" mother. At other times he perceived the analyst as a failing, incompetent, and "phony" professional, a projected aspect of his own self-image, while identifying himself with the grandiose superiority he had perceived in his mother. The treatment became a significant source of secondary gain because, as long as he still suffered from depression and insecurity, it made "no sense" for him to work, and he could thus avoid the deep feeling of humiliation in having to acknowledge his professional failure as a consequence of his own behavior. Perhaps more important, any attempt to resurrect his career would necessitate taking what he would consider a low-level position, which represented another intolerable humiliation. Only after an extended stalemate in the treatment, and following the analyst's insistence upon a return to work as a precondition of continuing the treatment, did the situation change, leading to a full deployment of feelings of hatred and humiliation in the transference, and opening the possibility of working through his narcissistic structure in that context. His sense of humiliation at having to work in an "inferior" position, the fantasy that the analyst was depreciating him because of that, and his envious resentment of the analyst's "better life" was worked through gradually, and eventually permitted the emergence of gratitude for the analyst's patience, and authentic dependency on a

loving maternal image. This development in the transference led in turn to significant improvement in his feelings toward his wife, and in his relationship with her. He was greatly improved at termination.

Case 2. A woman in her early twenties, a second-year medical resident, was referred to analysis because of serious problems in her relationships with colleagues, supervisors, and patients. The diagnosis was a narcissistic personality, and she started psychoanalysis with me under an arrangement she had made with her father, whereby he would pay for her treatment until she graduated from the residency, at which time she would take on the responsibility if the treatment was not completed by then. She made it clear to me from the beginning that she thought the treatment useless and outmoded, and that she was willing to give it a try only as long as she did not have to pay for it.

Analysis of this provocative devaluation of the analyst, which at the time I considered a narcissistic defense against dependency, opened up the complex dynamics of her family background. She described her mother as extremely controlling and yet totally uninterested in what her daughter was involved in and what her feelings were, and her father, who supported his wife completely, as nice but impotent. The patient said she had learned to manipulate him, however, and thus could use him to extricate herself from the mother's control without confronting her openly. Manipulation, deceptiveness, and ruthless control dominated the interactions of the patient with her parents and a younger sister. I had hoped to gradually work through her devaluation of me through analysis of the transferential replay of the family constellation. Two years later, however, as graduation approached and we reviewed where she was, and what the future arrangements for her analysis would be, the patient, though acknowledging that she had been doing much better in her work and that her teachers had noted her improvement, was nonetheless convinced that she had achieved all this by herself. She saw "no way" in which the analysis had helped her, and, of course, she would end the analysis the day her father would no longer pay for it. That is exactly what happened, an outcome that serves as awesome testimony to the power of narcissistic defenses against vulnerability and dependency!

The therapeutic approach to such cases must include attempts to eliminate or at least reduce the secondary gain of illness. I would point out to the patient that active involvement in work and its related interactional experiences and accepting responsibility for financing the

treatment are essential if it is to help the patient, and that such engagement is a precondition of carrying out a psychoanalytic

psychotherapy. Depending on the situation, I might give the patient a period of time, say three to six months, to achieve this goal, with a clear understanding that should it not be achieved, treatment will be interrupted. This condition constitutes a limit-setting that becomes part of the treatment frame and so requires interpretation of its transference implications from the outset. Practically speaking, these interpretations may focus on the unconscious motivation for the refusal of work, the salience of secondary gain, possible resentment of the therapist for threatening the patient's equilibrium, and the self-defeating aspects of the patient implied in his denying himself the well-being, success, self-respect, and enrichment of life that comes from successful and creative engagement in one's work.

With this modification in technique, it is often possible to overcome the secondary gain of illness. In many cases, however, the patient will find infinite excuses not to work, and may even recruit help from third parties (e.g., social workers or health care managers), who may call the therapist's attention to the fact that his “excessive demands” are increasing the patient's difficulties and symptoms. In different social systems and health insurance arrangements, the secondary gain of illness may appear in different ways, but I have been able to observe these dynamics under a broad variety of social contexts in different countries, including Austria, Finland, and Germany.

Pervasive Arrogance

This symptom may dominate in patients who, while recognizing that they have significant difficulties or symptoms, obtain unconscious secondary gain of illness by demonstrating the incompetence of the mental health professions and their inability to alleviate such symptoms. They become super-experts in the field of their suffering, diligently research the internet, check out therapists for their background and orientation, compare their merits and shortcomings, and present themselves for treatment “to give the therapist a chance,” but consistently obtain an unconscious degree of satisfaction in defeating the helping professions. They may suffer from symptoms such as chronic marital conflicts, bouts of intense depression when threatened with failures at work, anxiety and somatizations, and even significant chronic depression. This last responds only “partially” to

whatever psychopharmacological treatment these patients receive (and even to electroconvulsive treatment, which sometimes is questionably recommended). Not infrequently, the combination of psycho-therapeutic and psychopharmacological treatment leads temporarily to surprising improvement, which in these patients' view is due to the medication alone; the psychotherapeutic treatment is not considered helpful and becomes unnecessary (then later, the medication “does not work anymore”).

The sudden shift (noted earlier) from frail idealization of the therapist to complete devaluation may occur at any point. Sometimes, a treatment of many months' duration that has seemed to be progressing satisfactorily is unexpectedly disrupted by an intense onslaught of envy of the therapist that triggers a radical devaluation of him. The initial evaluation of these patients usually reveals an ego-syntonic arrogance that may evolve into grossly inappropriate behavior and rudeness in some cases, or be thinly masked by a surface facade of appropriate tactfulness in others. This characterological arrogance has to be differentiated from the syndrome of arrogance described by **Bion (1967)**. The latter includes intense affect storms in the transference and in the context of a psychoanalytic psychotherapy in which the patient's relationship with the therapist is firmly established has a better prognosis.

The pervasive arrogance explored here may be rationalized by the patient in terms of cultural or ideological features, as when a female patient rejects all male therapists because “they do not understand women,” while berating her female therapist for being submissive to men's rules, including those governing the therapeutic relationship. When efforts to undermine the female therapist's therapeutic frame fail, such a patient may withdraw triumphantly from the treatment with such a “rigid, subservient” woman. Similar rationalizations may involve racial bias, assumed political differences, or religious orientations.

Case 3. A woman in her mid-forties came to treatment because of chronic suicidal ideation, several nonlethal suicide attempts that had a somewhat histrionic quality, and a long history of depression that had not responded to antidepressive medication. She had been an office manager with responsibility for twenty to thirty persons, and indeed had held a series of similar positions, her tenure in each invariably following a recurring trajectory: at first she was very successful and energetic, impressing people with her intelligence and getting-things-done

attitude; eventually, however, she developed conflicts with coworkers, would erupt in temper tantrums, have unexcused absences, and, finally, either resign or be asked to. At the time she came to our clinic she had been unemployed for almost a year, and was disturbed over her difficulty finding a position at her level of expertise. She was married, and with great hesitancy mentioned that because of her husband's impotence they had not had sex in several years. At the point of history taking, my attempts to elucidate more aspects of this

sexual difficulty provoked an irritated reaction and an angry statement that this was her husband's problem and was irrelevant to her treatment. She said that she was perfectly satisfied with the marital situation, and refused to discuss it further.

She evinced symptoms of significant depression, but not indications of a major depression per se. Her unwillingness to provide much information about herself, beyond symptom reporting, was a first indication of an ongoing negativistic attitude that took the form of depreciatory comments about me from the first session on. She generally demeaned me and the treatment I was offering, while she adamantly insisted on the importance of continuing with the medication she was on (though it was not helping her). I arranged a consultation with the psychopharmacologist on our team, who recommended a shift of anti-depressant medication in combination with psychotherapy with me.

Although from the outset she was highly skeptical about our twice-a-week psychotherapy, she came punctually to all her sessions, complaining that the past session had not helped her at all. In fact, she would say, it had only made her feel worse. Given the severe breakdown in her capacity to work, the conflicted relationship with her husband (as revealed on further inquiry), and her general impulsivity and lack of anxiety tolerance (in addition to the typical narcissistic features of her personality), I diagnosed her as presenting a narcissistic personality disorder at an overt borderline level.

While attending our sessions regularly, she also eagerly requested sessions and telephone conferences with the psychopharmacologist. In fact, after a few weeks she declared that she was getting better, which she attributed to the medication and the understanding attitude of the psychopharmacologist. In the sessions with me, she talked in a despondent way about her daily activities, evinced a tendency to trivialize her communications, and responded to my comments with a derogatory rolling of her eyes, or with challenging questions, attempting to

draw me into an argument. She had looked up internet information about me, and showed clear resentment of my many publications by accusing me of using her for my “experiments,” with no consideration of her interests.

After a few months of treatment, I found out that she had been consulting with other therapists during the time she was in treatment with me, and had bought herself a self-help program that she compared with my statements in the hours, concluding, as she eventually confessed triumphantly, that she was learning much more from her tapes than from the hours. I was attempting to focus her attention on her derogatory attitude in the sessions, and how this replicated the problems she had experienced in her work situations, while at the same time it perpetuated her sense of being alone and not understood, given the fact that I had become so totally worthless in her mind.

After somewhat less than a year of treatment, and following my return from a vacation, the patient interrupted the treatment, telling me that she was doing very well, that medication had helped her, that she had found another job, and that she was ready to proceed on her own. She insisted that she was no longer depressed, that she was functioning well at work, and that her husband was not giving her problems.

The technical approach to these patients must include a very tactful confrontation and systematic analysis of the defensive functions of arrogance in the transference, pointing out to the patient in the process, from the very start, that, given his emotional disposition, there is a risk that the treatment will end prematurely due to devaluation of the therapist. Typically, the patient fears, by projective identification, that the therapist has a depreciatory disposition toward the patient, and that therefore, if the patient's superiority is challenged or destroyed, he will be subjected to humiliating devaluation by the therapist. Because the unconscious identification of the patient with a grandiose parental object is often at the bottom of this characterological disposition (and an important component of the pathological grandiose self), it is very helpful, from early on, to interpret this identification whenever possible. This identification with a grandiose and sadistic object seems on the surface to bolster the patient's self-esteem by protecting his sense of superiority and grandiosity; at bottom, however, the patient is submitting to an internalized object that stands against any real involvement in a relationship that might be helpful, an object profoundly hostile to the dependent and true relational needs of the patient.

This arrogant reference system supporting the patient's grandiosity may also be expressed by what appears on the surface as an opposite symptom: the patient declares himself so bad, or inferior, or damaged, or deficient, that nothing is going to change, that nobody is going to be of help. This surface self-devaluation may be totally resistant to any effort to explore its irrationality, and the patient's attitude of superiority to the therapist emerges precisely in the patient's systematic rejection of the therapist's understanding, in

his knowing better regarding anything the therapist may express that runs counter to the patient's protests of his inferiority. Here a real trap for the therapist is to be seduced into what on the surface would appear to be a "supportive" attitude, an effort to reassure the patient that he is not so bad, that there is hope, that he should not be so pessimistic. This approach would only reinforce this transference, in contrast to a systematic interpretation of the patient's arrogant attitude of superiority to the therapist, an attitude reflected in his systematic refusal to explore his behavior in the transference. Obviously, the profoundly masochistic and self-defeating aspects of the submission to a hostile introject also need to be explored systematically: a negative therapeutic reaction following the patient's sense of being helped by the therapist may reflect this dynamic in the transference.

Self-destructiveness as a Major Motivational System

This group of patients presents what, usually from the very beginning of their evaluation, impresses the experienced clinician as extremely grave conditions. These are patients with severe, repetitive suicide attempts of an almost lethal nature, attempts that seem to have happened "out of the clear blue," but are often carefully prepared for some time, and even gleefully engineered under the eyes of concerned therapists. In addition to these suicide attempts, chronic self-destructiveness may manifest itself also in self-destructive behavior in what might otherwise become gratifying love relations, a promising work situation, the opportunity for professional advancement—in short, success in any crucial area of life. At times these patients are seen in relatively early years of adolescence or young adulthood, when many opportunities lie still ahead of them in life. Other cases come to the therapist's attention much later, after many failed treatments, with a gradual deterioration of the patient's life situation, and an apparent search for treatment as a "last resort," which may induce a sense—or an illusion—of hopefulness in

the therapist, who believes the patient's life may still change. At times the patient may very openly state that he or she is committed to death by suicide, defiantly challenging the therapist to see whether he can do anything about it. Sometimes this defiant challenge comes to a head early, even as the treatment contract is being set up, with the patient refusing to commit himself to any contractual arrangements. Usually the family background of these patients evinces severe and chronic trauma-tizations, including severe sexual or physical abuse, an unusual degree of family chaos, or a practically symbiotic relationship with an extremely aggressive parental figure.

If antisocial features complicate the picture, the patient may be deceptive about suicidal tendencies, and the chronic lack of honesty and a psychopathic type of transference may preclude any possibility of building a helpful human relationship with a therapist. For example, one of our patients would ingest rat poison for suicidal and para-suicidal purposes. She was able to smuggle the poison into the hospital, and developed internal hemorrhages. Though she steadfastly denied her ongoing consumption of the poison to the therapist, her blood tests showed a continuous increase in prothrombin time. Eventually this psychotherapeutic treatment had to be interrupted, as she was obviously unwilling or unable to adhere to a treatment contract that made it a precondition for ongoing psychotherapy that she stop ingesting the poison. André **Green (1993)** has described, in connection with the syndrome of the "dead mother," the unconscious identification with a psychologically dead parental object. The unconsciously fantasized union with this object justifies and rationalizes the patient's complete dismantling of all relationships with psychologically important objects. In fact, the onset of this patient's ingestion of rat poison was coincident with a visit to her mother's gravesite.

Unconsciously, the patient may deny the existence both of others and the self as meaningful entities, and this radical dismantling of all object relations may constitute, at times, an insurmountable obstacle to treatment. In other cases, the self-destructiveness is more limited, being expressed not in suicidal behavior proper, but in severe self-mutilation that repetitively punctures the psychotherapeutic treatment and signals the unconscious triumph of the forces in the patient that promote self-destructiveness as a major life goal. Such self-mutilation may lead to the loss of limbs or severely crippling fractures, but stop short of the risk of immediate death.

Case 4. A music teacher in her mid-twenties consulted after a severe suicide attempt from which she was saved only by a near miracle. Having secretly accumulated an enormous quantity of various anti-depressants, sedatives, and hypnotics she stole from her mother (who was on chronic medication because of complex characterological problems and depression), she dug a grave for herself in the middle of a forest close to her home. It was early winter, with abundant leaves still on the ground. After swallowing her entire hoard of medication, she lay down to die in the grave, covering herself with leaves. After three days of fruitless search by the police, one more effort in that area led to a police dog finding her still alive.

She had chronically abused drugs, presented chronic charactero-logical depression, and had a long history of manipulation and dishonesty in school and in her family relations, despite her high intelligence and musical talent. Clinically, she fulfilled the criteria for

a diagnosis of malignant narcissism, that is, a narcissistic personality organization, strong antisocial and paranoid features, and ego-syntonic aggression (directed against herself, in the form of chronic, severe suicide attempts, and against others, in the encouragement of antisocial behavior that might get them into trouble).

Her father was a distinguished philosophy professor at a prestigious Protestant university, and the high respect he enjoyed in his community, a major intellectual center in the South, contrasted sharply with the chaotic, unconventional behavior both parents engaged in at home. Such behavior included the parents' playing with each other in the nude in the bathtub, while inviting their adolescent daughter to join them in conversation. Her father would play “tricks” on her mother that had a sadistic quality, and enjoyed sharing this pleasure with his daughter. The parents were concerned about their daughter maintaining “formal” behavior in the outside world, and with her keeping secret the chaos occurring in the parental home. Chaotic relations between the parents, fights and reconciliations, temper tantrums, and mutual blaming alternated with periods of almost studied indifference of the parents toward their children.

In the treatment, for an extended period of time, the patient was dishonest about her ongoing use of drugs and her manipulative efforts to seduce teachers at the music school where she was working toward a higher degree. Once that dishonesty (a truly psychopathic transference) and the underlying severely paranoid dispositions emerged

strongly in the transference and could be worked through, she eventually perceived the therapist as no longer an unreliable, dishonest manipulator (a projection of her own corrupt grandiose self), but as a person who was willing “to stick” with her and would not abandon her. Only then did she communicate openly the hatred she had felt for him and for anyone else who tried to help her.

In one of her dreams, she was in charge of a psychiatric ward and had made the decision to kill all the patients by gassing them on a day on which all their relatives were invited to a garden party. While they were celebrating in the garden, she had the patients killed inside the building. Severe suicide attempts occurred during the early part of the treatment, and ended only when the origin of this hatred, her wishes for revenge, and the desperate hope that the therapist would not abandon her could gradually be interpreted and brought together. This patient improved dramatically after approximately seven years of treatment, with a complete resolution of the syndrome of malignant narcissism. The working through of the transference involved periods of cheating and lying, both in her work and in the transference, forcing the therapist into a “paranoid” stance that she would triumphantly “diagnose” in the sessions. His capacity to tolerate this regression, to remain firmly moral without becoming moralistic, and to systematically interpret her defenses against guilt feelings in the transference eventually carried the day.

Alcohol and drug abuse or dependency may also express unconscious dynamics of this sort. In patients who suffer from these conditions, the direct effect of the addiction has to be differentiated from its dynamic function. In the context of such predominant and extreme self-aggression, that function may be a determined commitment to self-destruction that well deserves the name *death drive*. For patients with narcissistic pathology in whom the addiction is self-perpetuating by the physiology of drug dependence, detoxification and rehabilitation in the early stages of psychotherapeutic treatment may permit the psychoanalytic psychotherapy to proceed. Where, in contrast, the function of the addictions is to express a severe and relentless self-destructiveness as the major life goal, repeated periods of detoxification and rehabilitation demonstrate their uselessness and indicate the prognostic gravity of the case. Sometimes addictions serve to rationalize failures in work or a profession that might otherwise threaten the patient's grandiosity: these cases have a much better

prognosis than those in which unrelenting self-destructiveness is the major motivation.

This general constellation of extreme self-destructive motivation (which, as I have mentioned, may be clinically described as a dominance of the death drive), must be differentiated from a related development, namely, the most severe form of negative therapeutic reaction. Negative therapeutic reaction does not refer to negative transference, but to a clear and immediate worsening of the patient's condition whenever the patient feels he has been helped by the therapist. The mildest cases of this reaction can be seen in patients with a depressive/masochistic personality structure and unconscious guilt over being helped, a dynamic described by Freud that is relatively easy to diagnose and to resolve interpretively. A more severe form of negative therapeutic reaction is the most frequent type, and is characteristic of narcissistic personality disorder, though not exclusive to it. Here clinical worsening stems from unconscious envy of the therapist's capacity to help the patient: this highly prevalent transference development requires more complex interpretation and working through, but still is eminently workable. The most severe form of negative therapeutic reaction, the case we are considering here, reflects an unconscious identification with an extremely aggressive and destructive love object, accompanied by a dominant transference fantasy that only if the therapist is enraged or hates the patient is he really and honestly involved with him

emotionally. “Only someone who hates you or wants to kill you really cares for you.”

Case 5. I have referred in earlier work **(Kernberg 1975)** to a patient who developed strong wishes that I shoot her, with a fantasy that by murdering her I would be linked to her, in my mind, for the rest of my life. Under these circumstances, she could die happily, knowing I would never forget her! To this day, many years later, I am impressed by how strongly the “logic” of that statement impressed me at the time, so much so that for a moment I could not find an argument to contradict it. This patient improved very gradually, over eight years of treatment, after working through her severely masochistic behavior and having tempted me more than once to discontinue the treatment.

This disposition may emerge in a patient's relentless effort to provoke the therapist into an aggressive attitude or action against the patient, thereby transforming the relationship into a sadomasochistic one. This reaction is usually accompanied by desperate efforts to transform the assumedly “bad” therapist into a “good” one, to transform

the persecutory object into an ideal one, an effort that fails because of the patient's relentless need (a repetition compulsion, really) to re-enact this sadomasochistic transference. In contrast to patients whose primary motivation is a total dismantling of the object relationship, here there is an implicit recognition that the therapist has tried to be helpful: in fact, this experience is what triggers this particular negative therapeutic reaction. If the therapist is not provoked to an extent that may indeed lead to disruption of the treatment, the consistent interpretation of this fantasy and unconscious provocation may resolve the impasse. In dealing interpretively with this whole area of severe and dominant self-destructiveness, efforts should be made to disentangle this kind of relationship from the more extreme ones discussed above.

Sometimes the unrelenting need to attack, depreciate, and destroy oneself appears in starkly undisguised forms. These patients are persecuted by constant thoughts of being worthless, useless, empty, of having wasted their lives, and being interesting to no one. They are unable to obtain conscious enjoyment of any pursuit or activity, including all sexual experiences. What is striking about these self-accusations and differentiates them from the overvalued or delusional self-devaluations in major depression is the lack of any attempt to justify these extremely harsh judgments of themselves. The irritation and anger these patients typically show when invited to explain what gives them their sense of worthlessness contrasts with the efforts of depressed patients to convince the diagnostician of the reasonableness of their self-depreciation.

In the interaction with the therapist they produce the impression of an irritable and resentful stance, rather than the deep sadness or frozen despair that characterizes major depressions. When some achievement or indication of better functioning in an aspect of their lives is pointed out to them, these patients may respond with a rageful and denigrating attack on the therapist who dares to make such a statement. Indeed, they relentlessly reject and attack anyone at all who attempts to soothe or encourage them. Over an extended period, they tend to reduce and extinguish their working, professional, and social engagements, withdrawing into an empty, monotonous, and parasitic existence.

The gradual development and the chronicity of this syndrome, in contrast to the episodic nature of major affective illness, together with the absence of neurovegetative symptoms and or slowed psychomotor and cognitive processes, differentiates this constellation from major

affective disorders. These patients typically respond only slightly or not at all to antidepressant medication, or even to electroshock (when that is applied after nothing else seems to work). The contrast between their chronic self-devaluation, on the one hand, and their grandiose, spiteful, derogatory attitude toward whoever challenges their convictions, on the other, reflects a primitive grandiosity and arrogance that is part and parcel of their narcissistic personality structure, as well as their unconscious identification with the overwhelming power of a relentless internal destructive force (of which, at the same time, they are the victim). These patients may be considered extreme cases of what **Cooper (1985)** described as the masochistic-narcissistic character.

The treatment of these patients is lengthy and complicated and the prognosis reserved. A psychoanalytic psychotherapy usually is the treatment of choice, but attention must be given to the secondary gain involved in the social parasitism that may be part of the syndrome. It often becomes necessary to require, as a condition of treatment, that the patient engage in some activity, however limited, or preferably fulltime work or an advanced study program, together with a firm commitment to regularly attend the therapeutic sessions. The patient's intense rage with anything coming from the therapist that would seem “encouraging” or “supportive” often provides the first opening for the transference analysis. At such a point, the patient's unconscious sense of danger from any

nondestructive object relationship can be interpreted: a benign object challenges the power of the omnipotent, death-pursuing entity that controls the patient's mind, and it is that entity that provides him an unconscious sense of superiority as the only meaning in life.

The technical approach to the entire group of self-destructive patients requires, first of all, that we take very seriously the danger of the patient's ending up destroying himself physically. This self-destructiveness is an ongoing threat to the treatment, making this danger a selected theme of the interpretive work from the outset. The therapeutic contract negotiated with the patient is intended to establish the minimal conditions to ensure that the treatment will not be used as a "cover story" providing the patient the freedom or incentive for self-destructive action. This negotiation may not be easy, as the therapist has to make it very clear that the treatment will not proceed if these minimal conditions for ensuring the patient's survival are not met. Such conditions may include, for example, that the patient commit to immediate hospitalization should suicidal impulses become so strong that

he believes he will not be able to control them; or that he discontinue specific behaviors that threaten his survival.

Once the parameters of the contract have been agreed on as a condition of treatment, the patient's temptation to break it has to be brought up by the therapist, with an analysis of the unconscious motivation and gratification that such a breaking of the contract entails. The triumphal attitude of the patient in threatening to discontinue therapy, in dismantling the therapist's interventions, or in radically devaluing the therapy must be interpreted as a self-destructive effort to destroy any relationship that might be of help. The therapist has to be very attentive to any indication of a more honest approach to the therapist, some indication of a developing dependency, or any "glimpse of humanity" in the patient that shows up in the therapeutic relationship. These positive gains should be highlighted with the patient, along with the danger that he may be tempted to destroy them.

It is important not to confuse this area of psychopathology with clinical manifestations of an authentic major depression. A major depression would evince indications of severe self-devaluation or self-accusatory ideation; severely depressed mood leading to a frozen indifference; reduction in the patient's psychomotor expression; decreased capacity of concentration; and neurovegetative symptoms. In the presence of these conditions, the treatment for depression, including an appropriate use of antidepressive medication (and, under specific complicating conditions, such as extreme, uncontrollable suicidal intention, even electroconvulsive treatment) might be the treatment of choice. And, of course, the indication for hospitalization must be considered urgently. This is not the case for the patient group with the extreme form of narcissistic psychopathology that we are describing here, in whom the manifestations of major depression are absent and instead a haughty, derogatory, indifferent, or aggressively challenging attitude toward the therapist prevails, if not gleeful enjoyment of the therapist's assumed impotence.

By the same token, the patient's conscious or unconscious enjoyment of his superiority when engaged in dismantling the therapeutic relationship may induce in the therapist countertransference reactions of self-devaluation, depression, withdrawal, or angry rejection of the patient. Sometimes an overanxious commitment and desperate effort to provide the patient emotional support may lead to a sense of exhaustion in the therapist and a sudden emotional abandonment of the patient that

he may register contentedly. An optimal emotional attitude in the therapist would include a consistent self-exploration of one's ongoing commitment to the patient, a willingness to "hang in there" without any undue expectation of success, and a willingness to carry out the work as long as it seems reasonable to do so, but not when it is clear that minimal conditions for the continuation of psychotherapy are not being met.

Such an optimal emotional disposition on the therapist's part may be lost temporarily but, with an ongoing exploration of the counter-tranference, can be reinstated by a successful integration of the object relations implications of the countertransference into transference interpretations. In addition, it may be helpful to share with the patient the therapist's awareness and acceptance of the fact that the treatment may fail, and that the patient may end up destroying his life; that the therapist would be sad if that happened, but accepts the possibility that he might not be able to help the patient overcome this danger given the circumstances of the treatment. Such an attitude may reduce the secondary gain of the fantasized triumph over the therapist that is frequently a component of the complex transference dispositions of narcissistic patients.

Specialized inpatient services for severe personality disorders once allowed us to protect selected patients from their severely self-destructive behavior during the initial period of psychoanalytic psychotherapy. We regretfully must acknowledge that, with the disappearance— for financial reasons—of the availability of long-term hospitalization in these inpatient services, some narcissistic patients with extremely severe self-destructive and self-mutilating features, or with severe but potentially treatable antisocial

symptoms, may now be treated only with supportive psychotherapeutic approaches that are more limited in their effectiveness.

Predominance of Antisocial Features

Here we are dealing with the aggressive infiltration of the pathological grandiose self, both in cases where this is expressed mostly in a passive/parasitic tendency, and in cases where it takes an aggressive/paranoid form (in the syndrome of malignant narcissism). All cases of narcissistic personality disorder with significant antisocial features have a relatively reserved prognosis. Patients with the syndrome of malignant narcissism are at the very limit of what we can reach with

psychoanalytic approaches within the field of pathological narcissism. The next degree of severity of antisocial pathology, the antisocial personality proper, has practically zero prognosis for successful psycho-therapeutic treatment.

Paradoxically, the very severity of the aggressive/paranoid behavior of patients with the syndrome of malignant narcissism (its function being to confirm the power and grandiosity of the patient), facilitates the interpretation of this behavior in the transference. Self-directed aggression—suicidal behavior, for example—clearly represents a triumphant aggression toward the family or the therapist, or the triumphant "dismissal" of a world that does not conform to the patient's expectations; parasuicidal, self-mutilating behavior may indicate the patient's triumph over all those others who are afraid of pain, lesions, or bodily destruction.

These are also patients who in the treatment situation may show the syndrome of arrogance in a restricted sense, the interpretation of which may effectively resolve it. This interpretive work includes pointing out to the patient his intolerance of his own intense, envious aggression, which is expressed in behavior or somatization as a way to avoid acquiring full consciousness of it. The pseudostupidity seen in this syndrome, the defensive dismantling of ordinary reasoning and cognitive communication, defends the patient against the humiliating possibility of the therapist's interpretive work reaching him in meaningful ways. An inordinate curiosity about the therapist's life is a way to control him and to control any new sources of envious resentment.

Consistent interpretation of the syndrome of arrogance may in fact be a key factor in transforming the transference from a psychopathic into a paranoid one, a transformation that marks the beginning of the patient's capacity for self-exploration of primitive aggression he would otherwise have to act out. Helping the patient become aware of the intensely pleasurable nature of his sadistic behavior against the therapist and others is an important aspect of this interpretive work. This requires that the therapist feel comfortable in an emotional empathy with such sadistic pleasure: the therapist's fear of his own sadism may interfere with his fully exploring this issue with the patient.

Case 6. A woman in her early twenties consulted because of severe and chronic suicide attempts, breakdown at school, and an inability to maintain relationships with men because of intense attacks of rage when her demands were not fulfilled. She had been severely traumatized

by chronic physical abuse by her stepmother but had maintained an ambivalent, friendly though distant relationship with her father. She had been diagnosed as a narcissistic personality functioning at an overt borderline level, and she presented a typical syndrome of arrogance in the transference.

During our twice-weekly sessions of psychoanalytic psychotherapy, she would consistently make fun of me, mimicking how I speak, parroting what she anticipated I would say to her, and at times seeming to be enraged at the mere sight of me. Several times she made menacing gestures toward objects in my office, as if she would destroy or throw them. Her contempt for me was palpable. In spite of her intelligence, and her clear commitment to the treatment (she would not miss a session even during snow storms), the sessions were filled with these unrelenting attacks and a total unwillingness to listen to, let alone think about, anything I was saying. She perceived me as a carbon copy of her sadistic stepmother.

At the same time, she exhibited an inordinate curiosity about all aspects of my life, including my office, and would spy on me outside the sessions. She managed to get information about my private life, and my children, by getting herself involved in activities that would provide her such knowledge, and would then triumphantly let me know all she knew about me. It seemed clear that she was totally unable to tolerate any awareness that her intense hatred of me was a projection of what was in her, and because of that projected hatred she managed her fear by means of triumphant control and surveillance of me. I consistently pointed out that I believed she was not aware of her relentless attacks on me, because they were expressed only in behavior and were accompanied by no awareness of any feeling. This protected her, I pointed out, against the sense of pleasure in those attacks that she did not dare confess to herself. This

line of interpretation gradually increased her tolerance of her own hatred, and marked the beginning of a capacity to acquire an affective representation of the transference relationship expressed in that hatred, namely, her revenge on and yet identification with the abusing stepmother. Eventually, after nine years of treatment, she achieved a full recovery, embarked on a successful professional career, and established a satisfactory marriage.

Paradoxically, as I have mentioned, the situation is more difficult in the case of patients showing passive antisocial behavior, in the sense not only of passive parasitic exploitation of others, but of a severe

destruction of their capacity for any sense of concern or responsibility for relationships with significant others. This lack of investment in object relations is different from the active destruction and dismantling of them in the patient group discussed in the preceding section, who may have a much better integration of superego functioning and evince no overt antisocial behavior. Chronic irresponsibility regarding time, money, and any commitment made to others, including the commitment to therapy, are the hallmarks of antisocial behavior of the passive/parasitic subgroup of severe narcissistic pathology. We are all familiar with patients who frequently miss their sessions, come late, and don't pay their bill on time.

Here, rather than being directed at individuals, the antisocial behavior may take the form of a parasitic lifestyle including unnecessary reliance on public assistance or family support. In treatment one finds, with these patients, a chronic dismissal of the relationship with the therapist, often masked by a surface friendliness and "chatty" engagement that becomes a major issue in the transference, and that over time may convince the therapist that there is no real human relationship going on. The unconscious devaluation of the therapist has such an ego-syntonic quality that even its interpretation may not touch the patient, who may believe that the therapist has completely unrealistic expectations of what human relationships are all about, and is either dishonest or a fool who does not need to be taken seriously. In contrast to the other types of difficult patients I have discussed, here the surface manifestation of the transference may seem pleasant and nonaggressive; the profound tragedy of the dismissal or dismantling of the therapeutic relationship potentially available to the patient may be subtly disguised. Here therapeutic focus needs to be on the contradiction between an apparently friendly, calm surface and frequent absenteeism, missed deadlines and commitments, and the absence of any impact of the therapeutic work. It is important not to confuse this group with patients in our next category, who, despite relatively better social functioning and psychological organization, have a surprisingly reserved prognosis.

The Repression of Dependency Needs as Secondary Narcissistic Defense

In contrast to the various syndromes and dynamics discussed thus far, which usually may be diagnosed in a careful initial assessment, this next condition is very different, in that it appears initially to be much less severe than all the others mentioned so far and, at least in my

experience, is very difficult to diagnose at the beginning of the treatment. Rather, it emerges as a complication that eventually may dominate the entire treatment, rendering it almost impossible.

Case 7. This patient, a businessman in his mid-thirties, consulted because of chronic ennui, estrangement from his wife, and dissatisfaction with his work, although he was at a loss regarding what other occupation he would like to engage in. His marriage of eight years provided satisfaction that he was carrying out a conventional life within his community, but his relationship with his wife was estranged to the point that he was indifferent to, and indeed completely ignorant of, what was going on in her life. There was little information about his past. He described his parents as responsible and dedicated, but as so engaged in establishing their business situation as newcomers to this country that they had little time for him.

His main complaint, in fact, was that he had very few memories from the past, from his childhood, from school, and that was very puzzling to him, given that he had an excellent memory for business matters and "facts." The only symptom he presented, which again was puzzling to him, was a fear of injections, or of seeing blood; he would faint on seeing an accident in which there was any indication of physical damage.

My impression was that this patient presented a narcissistic personality, functioning at a relatively high level facilitated by severe repressive mechanisms that banished much of his childhood from conscious awareness. I recommended psychoanalytic treatment, and the patient entered analysis with me for a three-year period, after which, by mutual agreement, we shifted to a supportive modality.

The treatment was remarkable for the absence of any emotional relationship or dependency on the patient's part. The patient

himself was surprised that he developed no particular feelings in the transference, perceiving me "realistically" as an "agent" dealing with his mental health. His associations, in spite of all interpretive efforts, remained at a surface level, with a chronic trivialization of communication that would fill the hours. In spite of my alertness to narcissistic transferences, I was not able to help this patient gain any deeper understanding of himself. His dominant emotional experience in the sessions, as in life, was a degree of boredom that increased to the extent that it was hard for him not to fall asleep. Eventually, he would spend significant parts of most sessions in deep sleep. Puzzled about this patient,

I consulted with senior colleagues, who were similarly puzzled. The fact, however, that patients similar to this one have eventually shown dramatic changes after significant elaboration of their narcissistic pathology kept me hoping for a breakthrough that, unfortunately, never occurred in this case.

I have seen very few patients of this kind over the years, and I would not be able to say which factors may predict whom we can help and whom we cannot. Once in a supportive psychotherapy with me, this patient was able to increase somewhat his availability to his wife and children and accept the "boredom" of his work with greater resignation. After a period of time in which no further changes occurred, we agreed to terminate, both of us accepting the limitations of the improvement achieved.

This is a relatively rare type of patient, usually functioning at the least severe level of narcissistic psychopathology, where repression and other advanced defense mechanisms have developed sufficiently that the pathological grandiose self is well protected against the eruption of unconscious envy, against the awareness that dependent relationships are inherently humiliating, inferiorizing, and threatening. These patients display a dramatic lack of awareness of their psychological life, often presenting severe forgetfulness about extended periods of their past, about their dreams, and even about people who apparently were once important in their lives. This stands in contrast to excellent memory for professional or business-related operations and past developments. Although initially, due to their high level of functioning, they may seem to be good candidates for psychoanalysis, in treatment they evince such an incapacity for tolerating their fantasy life, for emotional self-reflection, for contact with preconscious mental experiences in general, that the sessions become remarkably empty and extremely frustrating for the analyst.

While in the countertransference with all narcissistic patients the temptation of the therapist to become distracted over extended periods, or to fall asleep in the sessions, may be a reflection of the patient's unconsciously treating the analyst as if he were not present, this development may particularly affect the countertransference with the patients we are focusing on here. In fact, these patients may themselves feel intense boredom during the sessions, fall asleep for extended periods, and then have great difficulty regarding any reflection on the meaning of this falling asleep. By the same token, the descriptions of their life

situation are filled with surface interactions that implicitly deny any deeper aspects of relationships.

There is little mention of these cases in the literature, but experienced therapists recognize this constellation in their patient population, and the relatively frequent failure of their treatments. Some experienced analysts, on perceiving these manifestations, do decide (often rightly) that these patients are unanalyzable and recommend alternative treatment methods (not infrequently with other therapists). Psychoanalytic psychotherapy with these patients tends rapidly to shift into a purely supportive approach, as the concreteness of their narratives lead the focus of the therapeutic interaction toward practical life problems. A supportive psychotherapeutic approach may indeed be the treatment of choice for many of these patients, who in many ways are functioning adequately, if with significant restrictions in their intimate relationships. If the presenting symptoms are indeed sufficiently mild or restricted, so that a major modification of their character structure would not seem indicated, a supportive psychotherapeutic approach may be optimal. If more severe problems in work and intimacy significantly limit their life, it may be worthwhile to attempt a psychoanalytic approach. Given their clinical characteristics, standard psychoanalysis may provide a greater chance than psychoanalytic psychotherapy to reduce the massive resistance derived from strongly predominant repressive mechanisms that reinforce and protect the deeper narcissistic defenses against their dependency needs.

Defenses against the Incapacity to Conceive of the Therapist as Having a Consistent Mental Life

It is probable that this highly complex defensive constellation may be detected and resolved only in the course of psychoanalytic treatment proper, remaining overshadowed in the psychoanalytic psychotherapy of narcissistic patients, where the intensity of primitive split transferences dominates the sessions. What gradually strikes the analyst of these patients over an extended period is an

alternation of sharply contradictory emotional relations to the analyst, while the patient remains remarkably unconcerned over the extremely contradictory nature of his emotional dispositions in the transference, and is apparently unable to respond with any increase of concern or reflectiveness to interpretive efforts to resolve the defensive nature of this dissociation.

Case 8. For example, one patient considered the analyst either "extremely brilliant" or "stupid," or "totally indifferent," or "corrupt," or "politically biased." This patient would immediately assume that the analyst had fallen asleep if he remained silent for some time, while at other times complaining of the analyst's too intense, penetrating comments regarding the patient's failures and shortcomings. The analyst's exploring any plausible stimuli for these shifting reactions revealed that none of these emotional relations had any basis in reality. For example, the patient's considering the analyst the "most brilliant thinker" would be expressed in the patient's insistent wish that the analyst help him with concrete advice regarding political or business problems about which the patient obviously had at least as much information and knowledge—if not more—than the analyst, making such requests absurd. Similarly, exploration of the patient's experience of the analyst as either politically biased, retarded, indifferent, or dishonest led to the patient's eventual, if only momentary, recognition that these perceptions were unrealistic fantasies. Yet these fleeting recognitions of the fantastic nature of all these perceptions did not influence them at all, and they would return regularly over a period of many months.

Eventually it became clear that the patient was treating the analyst as if he had no permanent internal life, no consistent, stable, or continuous relationship with the patient. The analyst, in short, was like a robot experiencing isolated feelings, mental brilliance or mental deterioration, dishonesty, rage, or indifference. By the same token, the patient experienced himself as constantly changing, so that the stream of his verbal communications in the hours seemed to him also a robotlike mechanical behavior with little relation to his life. Consistent interpretation of the projective identification involved in this process permitted its resolution only after many months of analytic work. Eventually he was able to work through this total fragmentation of his experience of himself and the analyst, achieving a capacity for authentic dependency that gradually allowed this analysis to evolve to a satisfactory termination. This situation might be formulated in terms of LaFarge's description of the "imaginer" and the "imagined" **(2004)**, mental representations reflecting the patient's view of the analyst and his experience of the view held by the analyst of the patient. In fact, a consistent focus on this patient's incapacity to conceive of the analyst as a person with an internal life brought about a gradually increasing, intense anxiety, leading eventually to an entirely new set of complex

transference experiences. The patient's chaotic description of his relationship with both parents, remarkably similar to the alternative types of transference developments mentioned before, now could be seen as a profound defense against deeper layers of consciously unavailable internal relationships with them. This relatively infrequent transference development has to be differentiated from ordinary narcissistic defenses against envy, the alternation between idealization and devaluation characteristic of narcissistic transferences, and the split-off transference storms of narcissistic personalities functioning at an overt borderline level. The subtlety of sharply contradictory, unchanging, mutually split-off long-term transference developments may become clear over an extended period of time. They may be the hidden cause of extended psychoanalytic stalemates, and if not resolved severely limit the achievements of the psychoanalytic treatment. Attention to such a development, and the analyst's asking himself to what extent the patient is concerned over constructing in his mind any consistent view of the analyst's personality, may help to highlight this problem earlier and facilitate its working through.

General Prognostic and Therapeutic Considerations

We may summarize briefly the major negative prognostic features that emerge in this overall category of "almost untreatable" narcissistic patients: secondary gain of illness, including social parasitism; severe antisocial behavior; severity of primitive self-directed aggression; drug and alcohol abuse as chronic treatment problems; pervasive arrogance; general intolerance of a dependent object relation; and the most severe type of negative therapeutic reaction. The evaluation of these prognostic features is facilitated by a careful and detailed initial evaluation of the patient. For example, regarding the nature of antisocial behavior, it is important to elucidate the extent to which it corresponds to simple, isolated antisocial behavior in a narcissistic personality disorder without other major negative prognostic implications, or to severe, chronic, passive parasitic behavior that augments the secondary gain of illness; whether what is present is a syndrome of malignant narcissism or, most important, whether we are facing an antisocial personality proper, of either the passive parasitic or the aggressive type. At times antisocial behavior may be strictly limited to intimate relationships, where it

expresses aggression and vengefulness, particularly when accompanied by significant paranoid features. This may be of particular note when the behavior is directed at the therapist in the transference; at times it may create such a high risk for the therapist that treatment under such circumstances might not be wise to attempt. This dynamic can be seen in patients whose aggressive, vengeful acting out takes the form of litigious behavior against therapists; they may initiate a lawsuit against a first therapist while idealizing a second who is "recruited" to repair the damage done by the first, only in turn to sue the second while transferring to a third, and so on. It may be wise not to accept a patient of this kind for intensive psychotherapeutic treatment while legal proceedings involving another therapy are still going on. Some patients with a hypochondriacal syndrome, and who are prone to accuse therapists for not having recognized the severity of some somatic symptom or illness, may be related to this group. In the case of patients with chronic suicide attempts, it is extremely important to differentiate suicidal behavior that corresponds to the authentic severity of a depression from suicidal behavior "as a way of life," not linked to depression, and typical of both borderline personality disorder and narcissistic personality disorder **(Kernberg 2001)**. Here the differential nature of the suicide attempts may be extremely helpful in diagnosing the patient's case.

The elimination or reduction of secondary gain of illness is one of the most important and often difficult aspects of the treatment, particularly in setting up the initial treatment contract and a viable treatment frame. The parameters of the contract provide assurance that the agreed-upon frame will protect both parties (as well as the therapist's belongings and life situation) from patients' acting out during the treatment. In the course of the psychoanalytic psychotherapy of patients with borderline personality organization—and this includes the patients I have explored here—the emergence of severe regression in the transference is practically unavoidable, and frequently takes the form of efforts to challenge and break the therapeutic frame. In the face of any such challenge, the therapist's physical, psychological, professional, and legal safety takes precedence over that of the patient. This means that while the therapist must ensure the patient's safety by setting up a contract and a treatment frame that protect both of them, the therapist's own safety is an indispensable precondition for his being able to help the patient. This would seem obvious or trivial, if it were not that so often therapists are seduced into treatment situations in which their

safety is put at risk. The contract must spell out conditions, specific to each case, that if not met by the patient would require discontinuation of the treatment. If necessary, these conditions must be reiterated as part of the treatment arrangements and then, as I have said, immediately interpreted regarding their transference implications.

Let me summarize the indications for the differential treatment I have presented. For the mildest cases of narcissistic psychopathology, a focused psychoanalytic psychotherapeutic approach or even a focal supportive psychotherapy may be the treatment of choice; only if the severity of the character pathology warrants it would standard psychoanalysis be indicated. Standard psychoanalysis would be the treatment approach for the second, or intermediate, level of severity and possibly for some cases on the severe spectrum of narcissistic patients functioning at an overt borderline level who, for individual reasons, may be suitable for such a treatment. However, for most cases of narcissistic pathology functioning at an overt borderline level or with severe antisocial pathology, the specialized psychoanalytic psychotherapy that we have developed at Weill Cornell Medical College, namely, Transference Focused Psychotherapy (TFP), is recommended as the treatment of choice **(Clarkin, Yeomans, and Kernberg 2006)**. When individualized preconditions for such treatment cannot be met in the initial contract setting **(Clarkin, Yeomans, and Kernberg 1999)**, a cognitive-behavioral or supportive psychotherapeutic approach may be the treatment of choice.

In general, a supportive psychotherapeutic modality based on psychoanalytic principles is indicated for cases where the patient's need for "self-curing" is so intense that any dependency is precluded; in such cases, active counseling and advice in a supportive relationship may be much more acceptable to the patient **(Rockland 1992)**. When severe secondary gain cannot be overcome, thereby greatly limiting the patient's prognosis with an analytic approach, a supportive psychotherapy focused on the amelioration of predominant symptoms and behavioral manifestations may be helpful. In cases with severe antisocial features that require ongoing information from outside sources and social control, technical neutrality may be too affected to carry out an analytic approach, and a supportive one would appear preferable. For patients who, as a consequence of their long-standing illness, have suffered severe regression into social incompetence, all their "bridges burned" behind them, making a realistic adaptation to life much more difficult, a supportive psychotherapeutic approach may be preferable to

a psychoanalytic modality. The latter would have to face them with the extremely painful recognition of having destroyed much of their lives: here the subtle empathic judgment of the therapist regarding what the patient may be able to tolerate becomes very important.

It needs to be kept in mind that before psychoanalytic knowledge advanced in the understanding of the psychopathology of pathological narcissism and helped us develop specific techniques for dealing with these patients analytically, the prognosis was much more limited for a much larger number of patients than is the case today. New developments in psychoanalytic psychotherapy for cases of narcissistic personality disorder where standard psychoanalysis would seem con-traindicated have significantly improved our therapeutic armamentarium. Continuous efforts to explore the cases at the limits of our present psychoanalytic understanding and capacity to help should expand the range of patients we can successfully treat. Given the high prevalence of this kind of pathology and its severe social repercussions in many cases, this is an important task for the psychoanalytic researcher and clinician at this time.

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