

# Case Study 1

## Narcissistic Personality Disorder

### **Presenting Problem & Client Description**

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Mrs. N. was referred by a friend of hers in the field to a colleague who referred her to me for treatment. Her chief complaints were feelings of chronic depression and diffuse anxiety. The colleague who referred her had also indicated that she was prone to angry outbursts, which a number of times resulted in having the police being called. These outbursts occurred in places of business, when traveling, with friends, family, lovers, and with neighbors.

Mrs. N. was a tall, attractive married woman in her mid-30s with three children, who looked slightly younger than her chronological age. She was the older of two children. Growing up, her father was an extremely successful businessman who had left her with a substantial inheritance. He was a self-made man who was “all business,” hostile and very derogating of her, and generally too busy for his children. After her father’s death, her mother remarried. Her mother was both physically absent and emotionally distant while Mrs. N. was growing up; although she provided for basic and nonemotional needs, Mrs. N.’s mother tended to use this support to coerce her children to do as she desired. This pattern of behavior continued into her children’s adulthood. Mrs. N.’s mother often provided the patient with loans and helped her with her finances, as much of her inheritance was unavailable (e.g., in the form of stocks). Because of the unavailability of these funds, Mrs. N. had difficulty managing her money and often relied on her mother to organize her finances. In return, her mother often put pressure on Mrs. N. about where to live, where the children should go to school, and other major decisions in her life.

Despite her overt perception that she had superior intelligence and abilities, Mrs. N. reported constant difficulties doing well in school and in sticking with any one of her multiple hobbies (e.g., horseback riding, acting, and singing). She generally blamed her parents for not encouraging her or helping her develop her talents. She perceived herself as having difficulty concentrating or at least following through on tasks. She

felt easily bored or frustrated with whatever she was doing. Despite her difficulties with money, she tended to hire assistants to carry out the more mundane aspects of her work and hobbies (e.g., she hired someone to take her horseback riding for exercise because she found having to do so boring and an imposition). Her difficulties sticking with hobbies were sometimes made worse due to angry outbursts she would have with friends, colleagues, or others involved in these activities. She would frequently change her mind with regard to which hobbies were most important to her and where she wanted to invest her time and efforts. She once sold a horse she owned because she had not ridden it in years, and then a few days later bought another after she saw a new horse she admired. The result of these patterns was that as she entered her 30s, she had not yet developed expertise in any one area nor did she have a stable sense of what she wanted to do with her life.

To gain the approval of her parents, she married a man who, while supportive of her and tolerant of her rages, was unable to provide sufficiently for the family, in part because he was disproportionately responsible for the children, and in part because he was probably identity diffuse himself. Her inheritance and support from her mother provided for the family and allowed both her and her husband to live comfortably but without steady career investments. She felt terribly put out by having children, found them to be quite a burden, yet needed them as an excuse for not having invested in a career path nor achieved tangible successes.

In addition to depressed mood and diffuse anxiety, the patient reported angry outbursts, significant alcohol and marijuana use, fleeting concerns about rapidly shifting interests, and unhappiness with the lack of success in her life. She was heavily involved with drinking and marijuana use. She felt considerably activated by routine situations and demands, and saw the alcohol and drug use as ways of dampening her internal experience. She shared that her husband was concerned that she was too disconnected from the children and overly frustrated with them, frequently losing her temper with them over rather developmentally normal stresses. By all appearances, she was quite brittle and needed much support. In addition to her mother's financial and logistical support, she had a housekeeper, gardener, au pair, and a number of babysitters to help her maintain the household and take care of the children. Additionally, her husband did not work regularly and was the primary caregiver who not only took care of the children's emotional needs but also brought them to all their lessons.

At times, Mrs. N. believed that her children and "unsupportive" husband were responsible for her "not making it" or becoming famous, and she had frequent fantasies of leaving her family and "making it big." She attended acting workshops and sang in a series of local bands, occasionally developing crushes on fellow actors or band members, particularly younger men. Sometimes these crushes resulted in affairs, sometimes in unrequited love relationships. She often fantasized about leaving her family and touring Europe with a younger man who would produce her music and help her achieve fame and fortune.

## Case Formulation

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The case formulation for this patient was derived over a number of sessions using Kernberg's (1984) structural interview. This is a psychiatric interview designed to elicit information in order to make a differential diagnosis between those with personality disorders and those with neurotic-level functioning (as well as those organized at a psychotic level). The diagnosis and case formulation are based on a synthesis of reported and observed clinical symptoms, inferred intrapsychic structures based on the content and organization of narrative data, and the quality of the therapeutic relationship as experienced by the interviewer. During the structural interview, the clinician obtains the following information: mental status, a complete symptom picture, the patient's current function, and the patient's sense of self and others. The structural interview is not only important in establishing a diagnosis and case formulation with personality disordered patients, but it is useful in gathering information that can be shared with the patient when providing feedback and in developing collaborate goals for the psychotherapy.

From the data that emerged, it became clear that despite her complaints, Mrs. N. did not meet criteria for any axis I disorder. Although there were some somatic symptoms, she did not have any of the neurovegetative symptoms of depression, nor did she report feelings of worthlessness or excessive or inappropriate guilt or recurrent thoughts about death. She did report depressed mood and occasional loss of interest in activities, but these states were variable, fleeting, and typically in response to a perceived interpersonal slight. In fact, rather than being anhedonic, she was particularly self-indulgent and pleasure seeking. Likewise, she did not meet criteria for dysthymia or depressive personality disorder, bipolar disorder, or an anxiety disorder.

Although at times she displayed elevated, expansive, and irritable moods, they never lasted at least a week (or even 4 days for a hypomanic mood); instead, these symptoms tended to be quite labile, quickly vacillating with depressed mood states as is more characteristic of personality disorders (Henry et al., 2001; Koeingsberg et al., 2002). This pattern was chronic as opposed to being present in discrete episodes as is the case with bipolar disorders. With regard to generalized anxiety disorder (GAD), her anxiety was diffuse, free floating, and variable. Her anxiety was also imbued with irritability and impulsivity, and the GAD diagnosis was contradicted by a variable presence of anxiety and long periods of lack of any anxiety, even in the face of anxiety-provoking situations. Although she had described an occasional panic attack, she did not meet criteria for the disorder.

As she discussed her functioning, she described situation after situation in which she flew into rages and made outrageous verbal attacks on those she was close to as well as strangers she encountered. She would fly into rages against her parents, her husband, her children, the au pair, her auto mechanic, her singing and acting coaches, lovers, and countless others. No one was safe from her wrath. On the section in which patients are asked to describe themselves and others, consistent with Kernberg's (1984)

theory, Mrs. N. was able to provide a relatively intact and coherent, if grandiose, description of herself, whereas her descriptions of others were quite impoverished. In terms of narcissistic personality disorder (NPD), she clearly displayed a pervasive pattern of grandiosity in her fantasy and behavior, a need for admiration, and described instances of clear lack of empathy for others. With regard to specific criteria, she (1) displayed a sense of self-importance that was exaggerated in terms of her achievements and talents, and she certainly expected to be recognized as superior without commensurate achievements; (2) described being preoccupied with fantasies of unlimited success, power, beauty, and ideal love; (3) indicated that she considered herself to be special and should associate with other special or high-status people; (4) described a clear need for excessive admiration; (5) displayed a sense of entitlement; (6) periodically was interpersonally exploitive; (7) had difficulty recognizing feelings and needs of others; (8) was often envious of others and believed that others were envious of her; and (9) at times behaved or displayed an arrogant, haughty attitude.

Based on her symptom picture, her functioning in work and love, and inferred psychological organization based on the quality of the narrative descriptions of self and others as well as the quality of her relatedness to others, it was felt that the panoply of symptoms she presented with could best be understood as occurring in the context of an NPD diagnosis. This is a woman who aggressively defended against feeling small and inconsequential to her parents—one of whom was hostile and derogating and the other who was cold and disengaged. Understandably, she deeply wanted to be with her parents, to be valued by them, and to be nurtured by them. She was angry with them and others, sensitive to any indication that she was being devalued, and prone to distort benign situations so as to feel belittled. In these situations, she quickly responded with extreme rage that often resulted in her being removed from a situation and/or the dissolution of previously established relationships.

I began working with Mrs. N. using a version of transference-focused psychotherapy (TFP; Clarkin et al., 2006) that was specifically modified for work with NPD. TFP is an empirically supported treatment for borderline personality disorder (BPD), a “near neighbor” disorder. This choice seems warranted due to the high level of comorbidity between BPD and NPD as well as the theoretical connection between NPD and BPD (Kernberg, 1975/1985). Additionally, there is some preliminary evidence that TFP is uniquely efficacious when compared with dialectical behavior therapy and supportive psychotherapy for narcissistic patients (Diamond, Yeomans, et al., in press). Nevertheless, in recent years a number of technical modifications of TFP have been made to accommodate differences in the pathology between these disorders (e.g., Diamond & Yeomans, 2008; Diamond, Yeomans, & Levy, 2011; Diamond, Yeomans, et al., in press; Stern, Yeomans, & Diamond, in press). These technical modifications will be described below.

## Course of Treatment

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I could tell from the onset that I was about to begin a challenging treatment. Mrs. N.'s opening volley to me showed both her aggression and her neediness. The very first thing

she said to me, referring to my office, was “Gee, this is the nicest broom closet I have ever seen,” which was quickly followed by reprimands for a series of perceived failures on my part: I had no watercooler in my faculty office, my office was too far from where she had to park, the weather did not suit her. Each of these comments was embedded in an angry “put-out” affect and resulted in my feeling both criticized and sad. She was hostile, but I hypothesized that part of her wanted me to care for her. She wanted me to provide nourishment, intimacy, and atmospheric comfort. And even before I said anything more than “come in,” she was angry at me for wanting these things from me. Her comments invited interpretations but to do so would have been too early, too exposing, and too penetrating. She would feel as part of me was feeling—that is, attacked without any good options. Immediately, I had a sense of the link between her neediness and her feelings of abandonment with her aggressiveness and superiority. I felt she wanted these things from me and she was sad that I could not provide them, but she was also angry at me that I had not provided them and that I evoked such desire in her. I also sensed that she took great pleasure in knowing that I was incapable of making a watercooler appear or moving the parking garage. And even if I could get her some water and find her a closer parking spot, I could not change the weather. Thus, it was me who was incapable, not her.

This dynamic continued, for as I explained my practice to her, she dismissed everything I said as if I was telling her things she already knew (despite the fact that this was her first therapy). When I told her my fee, she told me that I “would never get rich charging so little.” She followed this comment with stories of all the people who wanted a piece of her financially, as if she was made of money and others were corrupt users who wanted nothing more than to have what was rightfully hers. Infused in these comments were my presumed greed (i.e., that I was using her for my financial gain) but also its opposite—that I was not charging as much as I could, and therefore, maybe I was not a greedy money-hungry user. Additionally, she was scoffing at my fee as if it was inconsequential to someone with her money but at the same time expressing her concern that I didn’t really care about her besides the money. Early on, it was clear that her communications were complicated and represented a condensation of overt and covert narcissistic concerns.

Despite my experience of the patient as critical of me, she also spoke very glowingly about me, and it became apparent that her experience of me was very different than the way she talked to me. Mrs. N. described multiple situations in which she was hostile, disparaging, and rude toward others, and I experienced her as that way toward me, despite the intermittent idealizations. However, she saw herself as someone others attacked, derogated, coerced, imposed upon, and controlled. She could not acknowledge it, but it seemed to me from her affect and the content of what she was saying that she found me and my questions a terrible imposition. Someone was being imposed upon and controlled, and someone was imposing and controlling, but it was unclear to her who had what roles. She and I in the consultation room, and others outside it, vacillated back and forth in her scenarios.

As we continued the structural interview and I gathered information about her relationships and experience of others, she frequently talked about people in her life

that she thought were narcissists or had a personality disorder. She often spoke to me as if we were colleagues discussing her family members who were “our” patients. I began to experience dread about sharing my diagnostic impressions with her. I fretted how she was going to take it and imagined that she might lash out at me and end the treatment (part fear, part wish upon reflection). This was an unusual feeling for me. Although it can be difficult to share a personality disorder diagnosis with patients, it is important that clinicians convey diagnostic impressions in order to collaboratively set the treatment frame. I am not only an advocate of sharing diagnoses with patients but usually feel quite at ease and skilled when doing so. Despite my apprehension, I knew what I needed to do and dutifully did so. I did my best to be tactful and precise in my language and to utilize the material she shared in ways that I thought would resonate with her. To my surprise, she took the news very well. My descriptions of her experience and the psychological rationales I described resonated with her, but most important, despite her disparagement of those she perceived as narcissistic in her circle of family and friends, she disclosed that she had long suspected that she herself was diagnosable for NPD (in fact, she reported that she wondered about this for almost 10 years!). This was an important moment of both reflection and connection between us. We had a shared experience that I could now refer back to as needed. It was not just me who thought she was narcissistic; she too believed this.

The discussion of the treatment frame was easier now that we were both on the same page about the problems, and we discussed each of our roles and responsibilities in the treatment as well as the rationale behind them. She was less defensive, but I knew that this state was only temporary. When working with personality-disordered patients, it is important to have a clear discussion of the treatment frame or what is called the *treatment contract* in a TFP model. The contract-setting phase has multiple purposes. First, it educates the patient to psychotherapy. This is important for both the therapy-naïve and therapy-experienced patient because even those patients who have been in multiple treatments may have only minimal understanding of this particular type of therapy, in part because they may have been in therapies that utilized very different stances (e.g., supportive treatment, medication management, or cognitive behavioral therapy).

A second goal of the contract-setting phase is to establish a clear treatment frame that allows the patient and therapist to address and reflect on the material that arises in treatment, including feelings both in and out of session. The treatment contract creates a safe environment for patients that allows their dynamics to unfold with the therapist. By providing structure and clear expectations, it also provides a safe environment for the therapist to work within. Having an explicit agreement of the tasks and responsibilities of each party also provides an avenue for discussing and understanding deviations from the frame or contract. As Diamond et al. (in press) outline more fully, the contract-setting phase is more difficult with narcissistic patients because the expectations and responsibilities confront and limit the patient’s grandiosity and omnipotent control and often results in their perceiving the therapist as controlling and imposing. The frame or contract is often initially rejected or tested in ways that

may threaten the treatment. It is important when setting the treatment frame with personality disordered patients that the therapist utilize patients' past treatment experiences and relationship patterns to predict the kind of difficulties they might experience in the treatment. It is also important for the therapist to examine a patient's responses to the treatment frame to ensure that he or she is not simply acquiescing to the goals proposed by the therapist but is making a true commitment. With Mrs. N., I stated that although she felt what I was suggesting was reasonable right now, we might predict that at some later time she might feel differently and that it would be important to discuss those feelings as they arise.

It is not uncommon for NPD patients to begin therapy with either a haughty devaluing attitude toward the therapist or conversely with an idealization of the therapist as one who can magically provide solutions to all problems. Both these stances result from the need to sustain the grandiose sense of self and from the envy the patient experiences in relation to others. In both cases, the patient envies the therapist's functioning and psychological health. This conflict often leads the patient to devalue the therapist or aspects of the therapy and to either subtly or explicitly reject the therapist's interventions. In Mrs. N's case, she prefaced every acceptance of what I offered with "Of course." At other times, she made small tweaks to my wording. At still other times, she would reject what I said, only to come in the next week or sometime later and share with me her newfound understanding that was exactly what I had offered earlier but which she had rejected.

One important technique when working with narcissistic patients is to work outside the transference—that is, to discuss the transferences that patients show with people outside the therapy setting. These interpretations can have great immediacy and impact for the patient, and although they have been looked down upon within traditional psychoanalysis, they are consistent with the widening scope model (Bender, 2012). Another useful intervention with this population is to use "analyst-centered" rather than patient-centered interpretations (Steiner, 1994; Stern et al., in press). This type of interpretation focuses on the patient's experience of the therapist, typically in that moment, and is considered analyst or therapist focused because it stops short of interpreting the patient's motives to see the therapist in a particular way. Instead, the therapist allows the patient to hold this view of him or her without immediately challenging it, facilitating the examination of the patient's experience of the therapist more deeply and thoroughly. These extratransferential and therapist-centered interpretations with a focus on the patient's affective experience are ideally experienced by patients as validating but should not be delivered in a way that reinforces patient distortions. This is accomplished by maintaining technical neutrality and attending carefully to one's word choices and paralinguistic communication. From this nonjudgmental stance, therapists comment on patients' representation of experience rather than actual reality; over time, therapists introduce an alternate perspective that facilitates a more integrative sense of self and other. For example, a therapist might say: "When I asked about X, you experienced me as attacking you, rather than seeing me as concerned." The value of providing such validation while simultaneously providing

an alternative perspective in a gentle and matter-of-fact manner is that it invites reflection in a nonthreatening manner, and provides a base from which to build deeper understandings of the patient's experience. In this way, a therapist-centered interpretation, like extratransferential work, is preparation for a later transference analysis and transference interpretations.

These techniques were central to my work with Mrs. N. One theme that presented itself repeatedly was her sense that her various doctors and assorted helpers were not providing relief but instead making her worse. Over the course of weeks, she described how the various ministrations of her trainer, masseuse, chiropractor, and dentist left her feeling in pain. This led to discussions about whether she might be feeling the same about our work—that although she recognized that she was “getting better,” including experiencing more satisfying family relationships, she might also feel that there was a terribly painful downside to therapy. Over time, we were able to focus more on the transference and she found it more tolerable to discuss our relationship and possible distortions of it. This discussion led to deeper discussion about whether the work we were doing and the improvements she was experiencing were worth the effort, especially given her continued feeling that I was imposing my expectations on her.

Another turning point in the therapy came after I charged her for a missed session. The first few sessions after she received the bill were unremarkable, but a few weeks later she brought up how angry she was that I would charge her for a missed session. She reminded me that she had been up late the night before performing at a local venue and had overslept. We explored how she had held this feeling for a few sessions and the reasons why she might not have told me right away. It became clear that she wanted to protect me from her wrath and that only weeks later could she even broach the subject without flying into a rage. We discussed her need to protect me and her fear that I might cower, be destroyed, or abandon her. The fact that I could tolerate her anger, discuss it openly, not act defensively, and not retaliate was important to helping her integrate her own feelings into a productive discussion. I modeled maintaining a thinking stance in the context of an affect storm. We discussed how part of her worried about my motivations and whether I was only interested in her money. I wondered aloud if one could be interested in being compensated for one's time but also concerned about and wanting to be helpful to another.

The main vehicle for change in the treatment was being vigilant for indications of mental shifts that provided momentary windows into Mrs. N.'s more reflective, nondefensive spaces. The occurrence of these shifts between grandiose self states and depressed, defeated, and vulnerable states are difficult to predict. Nonetheless, these are highly valuable opportunities and the therapist must be vigilant for them and seize these moments. With Mrs. N., these moments came frequently and we developed a shared responsibility for noticing their occurrence and reflecting and exploring them. As we explored them in the context of her discussions of others, she also gained more awareness of when she was having this experience in relation to me and more tolerance for our examining her experience of me not as truths but as representations of me that might include distortions similar to the ones she had about others in her life.



One aspect that the therapist needs to be prepared for as the NPD patient improves is the true feelings of depression that arise with a more integrated experience and a greater capacity to take responsibility for one's behavior and mistakes. As Mrs. N. improved, she began to feel closer to her husband and children. She increasingly described more satisfying interactions with her children and delighted in their genuine appreciation of her. She began to be more attracted to her husband, ended affairs, and lost interest in potential other relationships. She also became more forgiving toward her parents, recognizing that they did the best they could and that they had experienced difficult childhoods themselves. She also recognized that, despite their shortcomings, they wanted the best for her and her sibling. However, she also began to feel very depressed and even guilty about missed opportunities with her family and her past behavior toward them. This represented a new stage in the treatment.

## **Outcome and Prognosis**

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Over the course of the treatment, Mrs. N. made a number of concrete, tangible, and clinically significant improvements. These included marked decreases in frequency and intensity of angry outbursts, alcohol and marijuana use, and feelings of detachment from her family. In addition to these changes, she showed a marked increase in her tolerance for distressing thoughts and feelings, motivation to work and capacity for ordinary functioning, and time spent with her children and husband.

In sum, Mrs. N. is now more productive at work, getting along better with coworkers, happier and more engaged with her children and husband, and happier in general. She is drinking socially but not smoking marijuana. Although she still feels tension quite often, she nonetheless is in much better behavioral control and only rarely loses her temper. Her internal experience of herself and others still is inconsistent at times and she is not completely free from symptoms of NPD. However, she is on the path toward more stable, realistic, and positive experiences of herself and others, and her prognosis is much better than when she entered treatment.

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