Chapter 2
The current state of clinical work: diagnosis, treatment and outcome

JUDY COOPER AND NILDA MAXWELL

Diagnosis

Why do we need diagnostic criteria for narcissism given that exact diagnosis is not necessary to begin treatment? The problem with narcissistic patients is their unassailability and their increasing demands on therapeutic resources. It would seem that narcissistic patients are equated with a very damaged object which is either the depleted/devouring breast or the damaged combined parental imago. What the narcissistic patient is unable to get from his primary object, he transfers with insatiable intensity to his analyst.

These features may often be apparent from previous therapeutic failures but otherwise they only become evident as the treatment progresses. Owing to the fact that the libidinal energy of narcissistic patients is chiefly spent in trying to repair damaged objects in their inner world, they appear entirely absorbed by this task and there is not much room for external reality or including the other's presence.

Can analysis really make a difference to this type of patient? The ones Freud did not want to touch and had traditionally landed up in psychiatric hospitals?

As more recent British publications have suggested, what is needed for working with these patients is either specialised further training (as in the USA) or highly experienced analysts/therapists with more than 10 years expertise (as in the UK).

Even experienced analysts acknowledge difficulties in assessing the depth of narcissistic disturbance until patients are well into treatment. It would seem that this is not altogether surprising because narcissistic patients so often put so much investment into their façade. Symptoms cover up deep pathology and frequently there is little to indicate any serious or deep-seated disturbance (Sandler et al., 1991; Glasser, 1992), what in Winnicott's terms has been referred to as the false self covering the true self (Winnicott, 1960). As one experienced analyst acknowledged: 'I only realise I am dealing with one of these patients when he is lying on the couch after leaving a knife on the chair.'

> Narcissistic wounds are special kinds of hurts – those that cut to the quick, that assail us where we live, that threaten our identity or our self-image, or our ego-ideal or our self-esteem. They are the hurts that go to the core. The emotional response to narcissistic injury is hurt, shame, and rage.
>
> *Levin (1993, p. xiv)*

Narcissistic difficulties involve disturbance in the experience of the self. It is important to discriminate between different degrees of severity. There is a vast difference between someone labelled mildly narcissistic and someone who is severely narcissistically disturbed and this will obviously reflect in the outcome of the treatment. Although the surface manifestations may vary and a person may display hysterical, obsessional or phobic symptoms, or even present what looks like a manic phase of a cyclic illness, the narcissist's core is split and feels dead. Other authors refer to this core emphasising grandiosity (Kohut) or aggression (Kernberg) (Russell, 1985). We believe that narcissistic disturbances could be grouped in three main categories:

1. The empowered or 'phallic' narcissist
2. The manipulative narcissist (sometimes thought of as 'psychopathic')
3. The impoverished narcissist (sometimes referred to as 'borderline').

Among all the variables that are associated with the narcissistic personality, we have chosen their immense difficulty in acknowledging dependency and have based these different types on this criterion. All three types present tremendous difficulty in accepting dependency but each type varies as to how they deal with this.

The empowered narcissist (phallic)

Although successful, their achievements have the function of supporting their self-image and conferring a sense of power. They tend to be hard and ruthless and their grandiosity is upheld by their being able to maintain an admiring response from others to their superiority. They are frequently charismatic, leading and organising others. Their impressive schemes often dazzle with their success but ultimately are not sustainable. Fostering personal relationships is irrelevant to their master plan.

The manipulative narcissist (psychopathic)

With their charming and often seductive façade, they have the ability to detect others' needs and to feed off these. They appropriate the usefulness of the other. Living in an atmosphere of excited expectation that

things are always about to happen, they appear to be optimistic. Their phantasies of success serve to provide the scaffolding for their grandiosity.

The disempowered narcissist (borderline)

Even when they *do* achieve, they cannot feel supported by their accomplishments. They appear not to be able to incorporate anything good because they have nowhere to put it (Resnik, 1995). They have feelings of low self-esteem accompanied in severe cases by fragmentation and identity confusion. However, the grandiose hallmark of the narcissistic personality is patently there behind a different façade.

A person can fluctuate either way between their adjacent categories (see Table below), so the manipulative can waver to impoverishment and visa versa, whereas the phallic includes the manipulative dimension always and the manipulative group could have fleeting phallic achievements. The distinction is one of degree. The empowered narcissist is not all powerful and the disempowered is not completely powerless. Essentially, in the case of the phallic types, their narcissistic injury is to some extent compensated for by their achievements and lifestyle, whereas the borderline narcissist, in spite of efforts to achieve a position of power, remains with deep feelings of powerlessness.

	Empowered	Manipulative	Disempowered
Sense of self	Precarious with obvious grandiosity	Precarious with wavering evidence of grandiosity	Precarious with no awareness of pervading unconscious grandiosity
Relatedness to others			
Quality:	Contemptuous	Multiple/superficial	When it happens: dependency and symbiosis
Style:	Control and power	Seductive/ manipulative	Fearful/passive
Goal achievement	High	Mainly fantasising	If it happens it is of no account to them

As Symington (1993) rightly points out: 'None of us is free from narcissism, and one of the fundamental aspects of the condition is that it blinds us to self-knowledge' (p. 10). Clinical experience currently agrees on listing five diagnostic criteria for narcissistic disturbances:

1. A grandiose sense of self-importance or uniqueness

2. A preoccupation with phantasies of unlimited success, power, brilliance, beauty or ideal love
3. Exhibitionism, the person requires constant attention and admiration
4. Cool indifference or naked feelings of rage: 'narcissistic rage', inferiority, shame, humiliation or emptiness in response to criticism or defeat
5. At least two of the following characteristics of disturbances in interpersonal relationships: entitlement (expectation of special favours without assuming reciprocal responsibilities), interpersonal exploitativeness, relationships that characteristically alternate between the extremes of over-idealisation and devaluation, lack of empathy and need to control.

Although it is acknowledged that narcissistic personalities may function extremely well socially, this is at a very surface level and beneath this veneer lies a ruthless disregard for others (Kernberg, 1975, p. 225). They are rarely guilty but always ashamed, constantly trying to live up to stringent ego-ideal prescriptions which should not be confused with superego demands.

Body

As in the Narcissus myth, these patients are either deeply in love with their own image as it stands, or believe that they can attain their ideal physical image one way or another (dieting, exercising, muscle building, plastic surgery, colon irrigation and so on). Their image can always be better and pain is forgotten in this frantic search to attain their phantasy of physical perfection. Gender transformation is an extreme manifestation of this search for physical perfection. Implantation or removal of body parts is increasingly endorsed by our culture as legitimate ways of pursuing this goal. All these manoeuvres seem to express a concrete search for a better breast (e.g. silicone implants, cosmetic mastectomies) or a displaced one (e.g. face lifts, body lifts, nose corrections, penis alterations).

Habitat/space

In our experience, this type of patient often lives in a transitional space. This is not in the Winnicottian sense of facilitating development, but, rather, in a way that stultifies any development. As Steiner (1993) said they find 'home' in external structures. Home is a shelter, a fortress, a carapace skin, so it is often a retreat where no one is allowed in and a state of limbo is ensured. Those who are never comfortable inside these structures become claustrophobic, and those who are never comfortable outside them become agoraphobic. None of them can accept limits: this would mean the end of the illusion which is what sustains them. Any

move towards establishing a permanent residence is experienced as threatening. They feel any change as catastrophic because they have had no holding to enable them to organise any real change. Indeed, some patients will retaliate if they feel under pressure to get settled. This was shown by a divorced patient who moved into the student quarters of the hospital where he worked and finally moved into his own home after a few years of therapeutic work, only to have an intense negative therapeutic reaction during which he wanted to end his treatment.

Time

Difficulties with time are never more evident than in the conviction with which these patients present their narcissistically invested projects. There is an elational and grandiose aura about these projects which have no reference to the passing of time or concept of age or death. A current illustration is the prevalent phantasy of a limitless age for fertility which is being encouraged by the scientific findings in this area. There are well-known cases of men and women believing that they will still have large families when they have not even started at 50 years of age. Alongside their unshakeable convictions of this kind, there is an indecisiveness and inertness and everything is conflictual, so that very often nothing moves.

Basic to this narcissistic way of thinking is the belief that it is the infant who creates and controls the good object. This illusion allows them to deny the primal facts of life which in Money-Kyrle's (1968) terms are the following:

1. The chief source of goodness required for an infant's survival resides outside him in the external world. This refers to acknowledging the separateness between self and object.
2. The recognition of the parents' intercourse as a supremely creative act. This refers to an acceptance of the Oedipal situation.
3. The recognition of the inevitability of time and ultimately of death. This means that all good things have to come to an end, and that access to the breast cannot go on for ever.

Money-Kyrle believes that coming to terms with these primal facts of life, without misrepresenting or distorting them, offers a measure of mental health. We know that narcissistic resistance will put up strong armour against acknowledging or working through these basic facts of life.

Treatment

In August 1967 Anna Freud writing to Kohut (Cocks, 1994, p. 171) refers to the widening of the field of psychoanalytic treatment. She states that the transference neuroses are easier to treat than the other mental disturbances called 'narcissistic disorders'. She alerts one to the

'impasses into which treatment runs if the narcissistic phenomena are treated on a par with the transference neurosis symptomatology'.

Unlike the borderline and psychotic patients both of whom experience empathy as threatening, the narcissistic patient is continually searching for merger to substantiate his fragile core. With these patients the analyst will get nowhere if he continues to work as if he is being cathected as an object. Confrontation, pointing out reality, problem-solving are not effective. In Kohut's terms, change is only possible if the patient can bear to experience the analyst as a 'selfobject'.

As with the treatment of children, Anna Freud felt that the analyst is rather used and 'drawn into' the patient's 'milieu':

> The patient uses the analyst not for the revival of object-directed strivings, but for inclusion in a libidinal (i.e. narcissistic) state to which he has regressed or at which he has become arrested.
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> *Cocks (1994, p. 171)*

It has been observed that very often the therapist is considered as a vehicle to be transformed magically and immediately by the patient's phantasies into a good or bad, protective or persecutory aspect of their internal world.

Turning to the Kleinian viewpoint, Hanna Segal (1983) in her paper 'Emergence from narcissism' tried to delineate Melanie Klein's contribution to this subject. As she states Klein made only two direct statements about narcissism and Segal found that implicit in Klein's reference was an 'intimate relation between narcissism and envy. . . To me envy and narcissism are like two sides of a coin. Narcissism defends us against envy . . .' (Segal, 1983, p. 270). Envy is so wounding given that it involves acknowledging that we are lacking what the other has. Envy implies that there is enough differentiation between self and object so as to allow a sense of deprivation. Rosenfeld, as part of this tradition, made a specifically British contribution (Mollon, 1993) to the study of narcissism where the concept of envy seems transformed from its initial formulation. Instead, he put forward the first description of a destructive mental organisation, an 'internal mafia', which he said accounts for the intense persecutory feelings of these patients. Similar formulations along the lines of narcissism as part of a defensive organisation are found in O'Shaughnessy (1981), Sohn (1985) and Steiner (1987). Although the usefulness of interpreting envy has become increasingly doubtful (Rosenfeld, 1987), the new concepts prove to be far more effective in the treatment of these patients.

The perfect fit

The subjective aspects of the patient–therapist 'fit' are particularly important for this group of patients (Higgitt and Fonagy, 1992; Rayner, 1992). The need for attunement of these patients manifests itself in

different ways, e.g. their intense demand to understand and be understood. Also, it is very important to keep the contract, the setting and the frame as steady and consistent as possible: to establish a 'rhythm of safety' (Grotstein et al., 1987). This safety refers to the tempo of the interpretations too: the therapist should be alert to vague or badly timed interpretations, as well as to whether they are too specific in an affectively charged way. Steiner (1993) quotes a patient who was 'stimulated to a violent attack when it seems I went too far or too fast' with the interpretations (p. 74). Quick analytic responses could be taken as a refusal to accept their projections and the feeling that their material is thrown back to them is taken as rejection. To create a therapeutic milieu where the patient feels safe, some analysts not only insist on delaying interpretations until a patient is ready for them, but minimise any expectation that they will have a mobilising function. It is generally believed that treatment should focus on the present whether this involves clarifications or looking at the therapeutic relationship. Mancia (1993) points out other difficulties in accepting interpretations. He shows how these patients act out inside the analytic setting by taking what they receive as their own:

> O's robberies occur in practically every session: the stolen object is the power and wisdom that he thinks is conferred by analysis on whoever possesses the method: put in simpler terms, my interpretations. O appears to accept my interpretation collaboratively, but instead of reflecting about it, metabolizing it, and using it for mental growth, he transforms it, manipulates it, and hands it back to me to demonstrate that my interpretation is incomplete, that he is much better at interpreting than I am, and that he does not need my work: he can do it alone . . . it makes no difference whether analysis is carried out with or without me, because he obviously wishes to negate every valuable aspect of the analytic experience . . . together with any painful feeling related to acknowledging my presence, his need for me, and the fear of separation.
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> *Mancia (1993, pp. 60, 64)*

These patients act out inside the analytic setting by 'stealing' what one gives them. They cannot acknowledge what they receive, rather claiming it as their own property. Sohn (1985) in turn has suggested that as a patient progresses in analysis 'he begins to feel that he has been robbed of his previously held special powers and that the robbery has been perpetrated by the analyst during the analysis' (p. 204). They cannot accept anything that they have not generated and which comes from outside themselves. They are bent on their own modes of self-cure (Khan, 1974, 1979).

Given the extreme difficulty that these patients experience with the passage from the merged to the separated state, some analysts feel that it is essential to try and keep a modicum of availability and continuity

going even in the holiday breaks. This is to counteract the tendency in these patients to act out their uncontained, overwhelming feelings at the terrifying experience of being on their own. Counter to this, other analysts maintain an extremely tight frame, similar to the environment that these patients have created in their own defensive organisation, so that the patient may feel protected from his or her own dread of chaos and more able to distinguish phantasy from reality. However, when this relationship is carried out in a flexible way, contacting the patient if necessary, e.g. following absences or holiday breaks, hospital visits, appropriate self-disclosure, etc. are not precluded as part of the treatment.

Dealing with aggression

The main differences in the treatment approaches of the three schools that we distinguish (Freudian, Kleinian and Independent) appear to be in their dealings with aggression. This controversy can be seen to go back to the Freud–Klein debate. Primitive impulses, persecution and mockery become genuine and real for these patients. The analyst should be able to withstand a patient's enraged and hostile transference as well as to tolerate the distortions about themselves and their reality coming from the patient's deeply split ego. As Freud said:

> the ego can be split . . . as a crystal thrown to the floor, it breaks but not into haphazard pieces. It comes apart along lines of cleavage into fragments whose boundaries, though they were invisible, were predetermined by the crystal structure.
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> *Freud (1932, pp. 58–9)*

In describing the structure of the narcissist's inner world, dominated by splitting and projective identification, some authors also include self-destructiveness, profound depression, grandiosity, dependency, envy and contempt. This last dimension has been explored at length by Grunberger (1989) who emphasises the anal component in narcissistic contempt.

Narcissistic transference and narcissistic rage

Today, much is written about transference psychosis. This refers to psychosis *in* the transference where the patient loses his sense of self, and his confusion is accompanied by unremitting hostility expressed by passivity or attacks on the analyst (Nissim Momigliano and Robutti, 1992). The narcissistic transference is somewhat different. With these patients highlighting regression, dependency or defences could lead to 'symbiotic relatedness'. Seinfeld (1993), referring to the handling of negative therapeutic reaction, quotes the writings of Giovacchini and Searles in the 1950s – they both emphasised the therapeutic value of the

symbiotic transference. This is in line with Balint's (1968) concept of 'benign regression' and Winnicott's of the regressive symbiotic transference as a psychic rebirth (1963). Seinfeld details the stages of symbiotic transference: idealised, ambivalent and finally resolution.

The three main schools that we have distinguished all try to disentangle the confused aspects of the self and to reduce the patient's high levels of anxiety. Each has a different approach in dealing with this crucial aspect of the treatment: the Kleinian school, mainly through Rosenfeld and other neo-Kleinians, believe that the primitive splitting and aggression of the transference psychosis can only be worked through by constantly interpreting and exposing the violent and sado-masochistic aspects of the transference relationship so that they can be integrated into the ego. Kernberg, on the other hand, coming from a classical position, although he has taken much from the Kleinians, insists on limiting the excesses of aggressive behaviour during analysis. He feels that the analyst should actively block this behaviour, establishing rules and limits whenever the safety of the treatment is endangered. Kohut, for his part, whose main ideas are very much on a par with the British Independent School, considers what the other schools define as pathological narcissism as various stages of immature narcissism or selfobject relating (merger, mirroring, idealised). What the others consider transference psychosis becomes, for Kohut, developmental pathways not experienced in childhood which can be reopened and connected through adequate mirroring. The vicissitudes of the self–selfobject unit are the vicissitudes of the child–parent dyad fitting together or failing to do so. In the treatment this re-enactment often results in a negative therapeutic reaction. Kohut says that the question to be asked is:

> . . . whether or not the patient is able to develop a selfobject transference when the opportunity to re-experience the selfobject of childhood is offered to him in the psychoanalytic situation. If the answer is yes, we will diagnose the patient as a 'narcissistic personality disorder', if the answer is no, we will diagnose him as 'borderline' . . . The line is not an immovable one.
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> *Kohut (1984, p. 219, note 7)*

As Kohut sees it, a person can be brought from immature selfobject relating to more mature ways of selfobject relating and, in the best cases, to separateness.

Much has been said about the limited range of affects of the narcissistic patient. They seem to yo-yo between anger and fear. The areas of feeling they *do* have and experience quite deeply are (1) the pain relating to their narcissistic injuries (schizoids never stop complaining) and (2) a sadistic awareness of what will hurt the other. Symington (1993) quotes Bergson: 'How does the wasp know how to sting in the right place?' It would appear that they 'feel' with minute precision where to sting in order to paralyse their objects without totally incapacitating them.

Kohut (1972) has emphasised narcissistic rage. He understood this *not* as pathological but as the justified response to injuries from which children cannot recover by themselves. Masud Khan's famous contribution (1974) on the concept of 'cumulative trauma' refers to the repeated experience of narcissistic injury. Khan was talking about the accumulation of relatively minor injuries whereas Kohut was dealing with the accumulation of more severe ones (Levin, 1993).

The different traits of the narcissist's personality that challenge the continuity and progress of the analytic treatment are represented in the myth of Narcissus who confused image and reality. What Narcissus saw mirrored in the water was the perfect lover he was longing for. The difficulties in grasping reality and the avoidance of self-knowledge, what have been referred to as the main active process of splitting in the narcissistic patient, have expression in the consulting room. First, it shows in a remarkable lack of connectedness with the analyst and, second, in a longing for a perfect fit. So, self-knowledge is avoided because it involves the destruction of the perfect image (Hamilton, 1982). This turning away from reality prepares the way for 'unreality' to take over.

Outcome

In our view the positive outcome of treatment could range from (1) using the narcissistic selfobject relationship in a positive way (Kohut) to (2) aiming for object-relationships with a decreasing degree of contempt that requires a shift in the inner structure (or object-relations) which is not always achievable (Kernberg, Fairbairn). This second more pessimistic view admits that even after treatment these patients still retain a degree of contempt for the object. The aim of increasing their social adaptability is, therefore, more realistic. However, (3) the Kleinian position emphasises working through the paranoid–schizoid splits until the mixed feelings of the depressive position are bearable and the reparative potential can emerge. Through this process the narcissist's powerful internal defensive organisation will be eroded and eventually given up.

Kohut writing to Khan in 1969 (23 September) (Cocks, 1994, p. 241) acknowledged the Kleinians as 'those who have committed themselves to the empathic immersion into the earliest states of mind'. This is undoubtedly true and, therefore, their contribution with this group of patients has been considerable in understanding them. Therapists belonging to other theoretical schools have taken from the Kleinian schema and benefited from it.

When dealing with severely narcissistic patients one must decide on one's aim in treatment: either to erode the enormous destructive ability of these patients or to work on fostering the more creative aspects of narcissism. On the whole, the Kleinians choose the first option whereas

the contemporary Freudians and the Independents tend to work with the second.

The degree of insight of these patients is variable and the therapist should be prepared to face complete lack of insight but this need not stand in the way of some change. As Rey (1994) underlined there is a schizoid way of being. If this is felt to be accepted, there may be different positive outcomes. Sometimes containment in the analysis gets rid of the more incapacitating aspects of grandiosity even if some elements of it remain. This would seem to be the case when the therapist tries to encourage and stretch every inch of his or her patient's developmental possibility. One must bear in mind that the developmental process is against these patients; as they age, the danger of this pathology increases given that the defences cease to be effective and the reservoir of libidinal energy gradually dries up. Mid-life is a point of vulnerability, and statistical material shows that attempted suicide is more frequent in this group of female patients who are in their thirties. Therapists are well acquainted with the narcissist's attempt to ally with the instincts (searching for the object), but because of the difficulties with connectedness, they frequently latch on to the ritual dance of life and death.

So much therapeutic energy with these patients goes into 'damage limitation'. There are phases when to avoid further deterioration becomes the primary aim of treatment. At these times anchoring them more securely in the real world (Bion, 1967) becomes a priority. The therapeutic investment then becomes absorbed in attempting to unveil, inch by inch, a little more reality, making it possible for the patient to use it.

With the progress of treatment it is possible to see some inner shift which allows more psychic flexibility and a little more room for the other. The slowness of the rate of change and the narrow margins of it should alert therapists to decide on their own suitability to treat this kind of patient. As Padel (1977, p. 1439) said:

> The psychoanalytic set-up is a bi-polar system in which both the members bear joint responsibility for change, good or bad, for lack of change, and – within limits – for the rate of change.

He adds that the way to develop a deeper understanding of these patients is by 'analysing the partial failures and not labelling them partial successes'.

Obviously, the expectations and outcome of treatment for the narcissistic patients vary according to the severity of the disturbance. Through analysis these patients can preserve or improve their surface adaptation and social functioning. Kohut, who pioneered this kind of rehabilitation, insisted on minimising the 'cosmetic solution' (false self). He preferred to foster creatively a use of the narcissistic grandiosity in the service of the more genuine aspects of the self, and thereby develop the ability to

accept pleasure. Somehow, with severely narcissistic disturbance, one may have to accept that the therapeutic result will never achieve a pure object-relations solution but lie somewhere in between object-relations and purely narcissistic relating. Kohut (1984) calls this 'mature selfobject relations'.

Symington, in his *New Theory of Narcissism* concludes that truly narcissistic individuals, however gifted, are able to cause considerable damage to the social structures to which they belong – to their families, their work organisations, clubs, societies (Symington, 1993, p. 10). For this reason, Symington feels that highly narcissistic people should never be appointed to key posts or senior positions. However, they frequently are. Symington's conclusion on the destructive effects of narcissism in all social structures is relevant in the specific case of the family. When these patients do have children, clinical evidence shows that they cannot foster the process of separate development. They disempower their children, experiencing them merely as an extension of themselves. Follow-up research shows that there are differences in outcome for males and females. Males seem to have more difficulty in marrying than females. And females, intent on preserving the symbiotic bond with their partners, do manage to sustain a relationship but frequently have difficulties in having children. As it has been said: 'The world is pretty much run by narcissistic personality disorders . . . they can usually "perform"' (Levin, 1993, p. 242).

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