

A Case Report of the Treatment of Narcissistic Personality Disorder with Transference Focused Psychotherapy

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Abstract

Transference-focused psychotherapy (TFP) is an evidence-based, psychodynamic psychotherapy empirically validated for patients with borderline personality disorder (BPD) and successfully adapted for the treatment of narcissistic personality disorder (NPD). Personality disorders are characterized by the behavioral and affective dysregulation associated with pathological identity formation. Based on contemporary object relations theory (ORT), the goal of TFP is symptom relief through improvement in self and interpersonal functioning. The TFP treatment frame, established through an initial contracting phase and combined with the therapist's technical neutrality, facilitates activation, identification and containment of affectively charged perceptions of self and other. These perceptions, or object relations dyads, are repeatedly identified, labeled and explored through the interpretative process. Over the course of treatment, the patient's capacity for affect containment and reflection improves and a better integrated, realistic sense of self develops consistent with healthier personality functioning. Utilizing a compilation of several patients, the treatment of NPD with TFP is described and the evidence for the efficacy of TFP for NPD is summarized.

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Keywords: narcissism, narcissistic personality disorder, transference focused psychotherapy, psychodynamic psychotherapy, object relations theory, technical neutrality, interpretation.

Transference-focused psychotherapy (TFP) is an evidence-based, manualized psychodynamic psychotherapy designed to treat personality disorders (Caligor et al., 2018). Empirically validated for patients with borderline personality disorder (BPD) (Clarkin et al., 2007), TFP has been adapted and successfully applied to individuals with narcissistic personality disorder (NPD) (Diamond et al., 2022) or narcissistic traits. Based on contemporary object relations theory (ORT) with the integration of findings from neurocognitive and attachment research, TFP focuses on the pathology in self and other functioning that is central to the behavioral and affective dysregulation characteristic of personality disorders. The goal of TFP is to improve

self and interpersonal functioning, with symptom relief and resolution of maladaptive behaviors (Caligor et al., 2018).

Following a careful diagnostic assessment and case formulation, the TFP treatment frame is established via a mutually agreed upon verbal treatment contract between the therapist and the patient designed to control treatment interfering behaviors and limit acting out (Caligor et al., 2019). The structure provided by the treatment contract also supports psychodynamic exploration, with attention to the patient's external as well as internal life and a clinical focus on the here and now (Diamond & Hersh, 2020). TFP is typically a twice weekly psychotherapy. The therapist actively attends to the patient's emotional experience and behavior in each session, paying particular attention to disturbed interpersonal behaviors in relation to both the therapist and significant others (Caligor et al., 2018).

The TFP model focuses on *internal object relations*, affectively charged mental representations of self and other that organize subjective experience and interpersonal relationships (Kernberg & Caligor, 2005; Caligor et al., 2018). Patterns are encoded in object relations dyads composed of an image of the self interacting with an image of another person, linked by an affect such as love, hate, guilt, shame, joy, happiness, anxiety, or fear. In normal identity formation, object relations organizing the sense of self and others coalesce to provide a coherent, realistic and continuous sense of self across time and a corresponding experience of others, associated with affective experience that is complex and well modulated. In contrast, personality disorders are characterized by pathological identity formation in which affectively charged, predominantly negative experiences of self and other fail to organize into a complex, coherent and consistent sense of self. These poorly integrated, affectively charged dyads manifest in the therapy as they serve to organize the patient's descriptions of relationships with others and as they are enacted in the relationship with the therapist. (Caligor et al., 2018).

The TFP treatment frame and the therapist's stance of technical, or therapeutic, neutrality facilitate activation, identification and containment of maladaptive dyads in the safe and controlled therapeutic setting (Diamond et al., 2022). The therapeutically neutral therapist observes all of the conflicting forces within the patient and allies with the part of the patient that has the capacity for self observation (Caligor et al., 2018). Through the interpretative process, affectively charged perceptions of self and other are identified, labeled and explored, in relationship to the therapist and other interpersonal relationships. The initial intervention is to define the dominant object relations organizing the patient's experience in the moment. In patients diagnosed with narcissistic personality disorder, the dominant dyad is often of someone superior and devaluing in relation to someone inferior and inept, associated with an angry or hostile affect (Diamond & Hersh, 2020). The process of interpretation is carried out repeatedly throughout the course of treatment in an effort to improve the patient's capacity for affect containment and reflection.

The objective of TFP is the patient's development of flexible, mature mental representations of self and other that are integrated and reorganized over the course of treatment, promoting identity consolidation and conferring a coherent, realistic and stable sense of self (Caligor et al., 2018). The following case presentation utilizes a compilation of several patients to describe the successful treatment of NPD with TFP including the challenge clinicians may have in arriving at the timely diagnoses of NPD when difficulties related to personality are obscured by the patient's presenting symptoms.

Case Illustration:

Presenting Problem and Client Description :

Henry was a 25 year old single white cis-male, the older of two brothers, who presented after relocating from the west coast in the summer before starting a graduate program in community health. He was a tall, slim attractive man dressed neatly in casual clothes. His hair was worn long with bangs that fell into his face and over his eyes. He entered the office somewhat sheepishly, thanking me for seeing him. He requested treatment with medication for anxiety and low mood related to severe, intermittent abdominal pain. He had been experiencing this discomfort since a bout of food poisoning three years ago after graduating with honors from a prestigious university. He had not secured a job prior to graduation and thus returned to his family

home on the west coast. Soon after arriving home, he developed acute gastrointestinal distress following a family barbecue. He experienced excruciating abdominal pain along with other uncomfortable physical symptoms that continued for a several days leading to a brief emergency room visit where he was diagnosed with Salmonella poisoning, received intravenous fluids and was discharged. Intermittent abdominal pain persisted for many weeks, particularly after eating. He consulted a gastroenterologist who completed an extensive workup that was inconclusive. The pain made it impossible for him to find or sustain employment and kept him dependent upon his parents, particularly his mother. She was a homemaker who more recently worked part-time as a sales associate in a small women's fashion boutique. She was also an avid runner. Henry described her as very supportive and remarked that they were very similar. He described his father, an attorney, as aloof and sedentary. Henry suspected that he was skeptical that Henry had a true medical illness, though he had never said so. His parents had supported him over the prior three years of unemployment, permitting him to live at home and traveling with him to various medical and homeopathic specialists for which they paid. He expressed his frustration with the doctors he consulted as they did not appreciate the severity of his symptoms and the impact on his quality of life.

He had begun seeing a nutritionist several months prior to meeting with me who had recommended an elimination diet to identify food sensitivities which was helping. He denied any history of eating disordered thoughts or behavior. Although he was restricting the variety of foods in his diet, he was consuming adequate calories to maintain an appropriate weight for his height. Despite his relief in his improvement, he worried the pain would recur. He imagined being unable to complete his graduate program, returning to his parents' home and abandoning any hopes of an independent adult life. He felt guilty for relying on his parents. He also reported being socially isolated over the last few years because his college friends were living on the east coast. Few reached out to him and when they did, they seemed disinterested in his difficulties and preoccupied with their own lives. He reported he did not have many friends in high school but had developed a few close friends in college who had similar interests in fantasy literature and movies. He had two prior romantic relationships with women in college that lasted approximately six months to a one year.

While unable to work consistently over the past three years, he had volunteered at a women's shelter. He expressed sympathy for the women residing there, describing them as victims of societal misogyny. He said he was proud of his ability to sympathize with them which he believed was a unique trait in a man. He decided to apply for a graduate program in community health to help the disenfranchised. He applied to only one school on the east coast with a high acceptance rate in order to guarantee merit-based financial support and distance himself from home. Upon being accepted, his anxiety about recurrent pain amplified. He briefly saw a psychologist through his insurance plan who he described as nice but unhelpful. He had no history of other treatment, mood symptoms, psychosis, substance abuse or overt trauma. He reported periods of low mood, lasting days to weeks, throughout high school and college. He denied any suicidal thoughts or intent, but admitted to moments over the three years when he was overwhelmed by pain and had fleeting thoughts of suicide as a way to put a stop to it. At the time of his evaluation with me, his mood and energy level were somewhat low. He reported difficulty falling asleep at night. His current living situation in university housing was adding to his stress as it was loud and the kitchen was small, making it difficult for him to store and prepare his food. He explained that it was too expensive for him to live off campus. While he acknowledged he might benefit from treatment with both psychotherapy and medication, he could not afford to see me regularly for therapy and expected to be seen less frequently for medication management.

Case Formulation :

Henry was a likable, demonstrative young man who articulated his feelings and took time to answer my questions in a seemingly thoughtful manner. He demonstrated some insight by acknowledging his fears were unreasonable and could benefit from treatment. He expressed some motivation to address his symptoms and improve his overall functioning. Diagnostically, his presenting symptoms were consistent with an adjustment disorder with mixed anxiety and depressed mood. Although I appreciated that food sensitivity, allergy or poisoning may have been the initial cause of his abdominal pain, I thought that anxiety about his

independence and separation from his parents was a contributing factor. I deferred diagnosing a personality disorder but suspected that his level of personality organization was on the border of neurotic and high borderline (Yeomans et al., 2015). I shared my diagnosis of an adjustment disorder and my recommendation that he engage in a psychodynamically psychotherapy to address his vulnerability to feeling put down by others and his anxiety about his dependency on his parents. We agreed that he would follow up on more affordable psychotherapy referrals that I provided while continuing to meet with me for medication management for which his parents would pay. He would see me weekly for four to six weeks until his medication dose was therapeutic at which time sessions would be required once every three months.

When he returned, he reported an immediate improvement in his anxiety after meeting with me. He was impressed by my assessment and thought I took his concerns seriously. He said I understood him more than other doctors. He met with me weekly over the next five weeks through which he tolerated a titration of the medication without side effects. The theme of his sessions was his frustration with others, such as his father, who repeatedly let him down by dismissing his concerns. He complained about students in his dormitory putting items in the shared refrigerator with no regard for his food sensitivities. He requested to continue seeing me weekly for another month as he had not had time to follow through on the referrals, confirming that his parents would continue to pay. At this point, he began to criticize my office location and fees. He said it was unjust that a student like himself could not afford to see me without financial support from family. He compared my office location to that of his family's home which he described as a wealthy area removed from the daily struggles of most Americans and where his neighbors were consumed by materialism. I learned that his family was wealthy and he had refused his parents' offer to pay for graduate school, choosing to accrue debt instead.

Towards the end of the second month meeting with me, Henry expressed frustration with how slowly the treatment was progressing. I validated his frustration with the time needed to elicit change through psychotherapy and reminded him of the improvement in his abdominal pain and anxiety. I recommended we revisit his treatment plan after I returned from a one week vacation. He said he was disappointed that he would have to wait. While I was away, he cancelled the appointment. He returned three weeks later, stating that his mood and abdominal pains had significantly improved and he would find a more affordable therapist. He planned to continue the medication. Three months later, he requested an appointment to discuss discontinuing the medication. I offered my first available appointment in two weeks and agreed to refill his medication until then. He did not respond for four months when he called to apologize for his delay and schedule an appointment. He had stopped his medication three months prior and was feeling anxious and depressed. He had begun therapy with a social worker who he described as nice but inexperienced. He had accelerated his coursework and completed his masters degree. He did not attend his graduation as he did not feel any connection to his classmates. He had started an administrative job for a female professor whom he admired but was now feeling disappointed in her lack of mentorship. He had rented a room in a house near campus where the other residents had a history of living with each other, making him feel excluded and lonely. He was angry with a woman he had been romantically pursuing because she had gotten back together with her ex-boyfriend. He wanted help in understanding why he was attracted to women who did not appreciate him. I suggested that based on his description of other relationships, he seemed to feel similarly unappreciated and dismissed by family members and friends. He agreed with this suggestion and speculated that there was something about him that made others treat him this way.

I came to observe Henry as both grandiose, through his critical comments and dismissive behavior of others, and vulnerable, as he felt easy criticized and devalued by others. The oscillation between his grandiosity and vulnerability seemed to underlie his anxiety and depression and is characteristic of those with pathological narcissism (Diamond et al., 2021). I was now appreciating the difficulties related to his personality that were obscured by his presenting symptoms. Like other higher functioning patients with narcissistic pathology, the grandiose or ideal aspects of his sense of self did not prevent him from functioning in school and work. His grandiosity had not been obvious upon initial evaluation (Caligor et al., 2007), and I came to see that it was communicated less as self importance and more as a special suffering and a sense of being on a moral high ground. I shared my impression with Henry that, due to a confluence of factors, both biologically and

environmentally, he had developed some rigid personality characteristics that influenced how he experienced himself and others, often leaving him feeling alone and let down. I went on to connect this loneliness and disappointment with his vulnerability to feeling anxious and depressed. I reviewed his goals of treatment which he agreed were to maintain more consistently good feelings about himself in relationships with less anxiety and low mood, and to be able to sustain meaningful relationships over time. I recommended he begin TFP with me, explaining that it was a twice weekly psychotherapy that focused on his thoughts and feelings about himself in relationship to others including me. I said that his thoughts and feeling about me may be similar to those he has towards others, and if he worked to understand them through the treatment, it would translate to his other relationships. I clarified he would have to tolerate his resentment about my practice location and fees as well as his need for financial support from his parents. I encouraged him to speak with current therapist and parents which he did and they agreed.

I then set up the frame of the treatment by discussing the treatment contract, which included establishing mutually agreed upon goals for treatment, the frequency of sessions and the expectation of our respective roles as patient and therapist. He agreed to attend sessions on time and speak freely about what was on his mind, specifically about his difficulties in relationships and any thoughts or feelings he had about me. Although I strongly recommended meeting twice per week, he could only commit to meeting weekly. I explained that meeting more than once per week would provide greater opportunity for feelings to develop about me so we could work to understand them. I clarified that the depth and pace of the treatment would be lower and slower when meeting once per week. He was uncomfortable asking his parents to pay for two sessions per week.

Course of Treatment :

First Phase: Weekly sessions for one year. Henry had moments of fleeting nausea and abdominal pain and questioned whether or not his discomfort was real or imagined. He shared his feelings of disappointment at work where he believed he was undervalued by his boss and co-workers. His experience of feeling devalued alternated with his need to be admired. Any awareness of this need triggered self loathing that manifested in depression. For example, he put in extra unpaid hours at work organizing office supplies and ordering replacements for things that others did not know were needed. He expected to be showered with praise and felt humiliated when, not only did no one comment on the changes but, his boss questioned the need for the purchases. This experience led to angry feelings and critical thoughts that his boss was not only thoughtless but moronic. His abdominal pain recurred and he took to bed, missing work and a happy hour that followed. I validated his feelings and began to clarify his experience of himself in relationship to others, identifying repeated dyads in which self or other was experienced as inferior or superior and vice versa.

It was not long before he expressed conflicted feelings about the treatment. He was aware he needed help but was preoccupied with thoughts that my practice location and fees did not align with his ideals, I empathized that those thoughts must make it difficult for him to accept my help. I clarified his experience of me as alternating between an idealized experienced therapist who could help him and a devalued, overtly materialistic person who could not relate to him. When I suggested that I may not be the ideal or perfect therapist but may be good enough to help him, he admitted that his perception of me alternated between all good or all bad. I suggested he may also experience himself in those extremes and he shared his self critical thoughts of not meeting his idealized goals of frugality and self-sufficiency.

He returned to the next session stating that the prior session has been valuable because he felt understood by me but could not articulate how. He spoke critically about his parents' wealth and how they carelessly spent money. He was ashamed by their lifestyle and determined to distance himself from it. He talked about how, growing up, he did not fit in with his family and their local community. While attending private schools, he felt pressure to succeed both academically and athletically and had difficulty making and sustaining friendships. He attributed his difficulty to the overt competitiveness and materialism valued by his peers. While his decision to attend a large public university gave him access to peers with similar interests in social justice, he resented the continued competitiveness, particularly around securing a job upon graduation. He chose not to attend any of the job recruitment events on campus in his senior year. He believed that those

who did were supporting and submitting to cooperate greed. I empathized with his experience of isolation in the past while noting that, despite changing his location and attending a less competitive graduate school with peers who shared his social values, he still did not feel that he fit in. Following my observation, he appeared sad. He said he was worried there may be something wrong with him, demonstrating some capacity for reflection.

He shared a dream in which he came to my home where I was meeting with someone else and I asked them to leave in order to meet with him. He recalled feeling excited in the dream that he was allowed into my home and gratified for being chosen over another. When I asked what his thoughts were about the dream, he said he imagined that my home was serene and minimalistic unlike his parents' which he described as disorganized and cluttered. I noted his idealization of me to him. When I asked for his thoughts about being chosen over another person, he said it made him feel special. He described the gratification he experienced using dating apps because women choose him over other men. He described recently meeting a woman on a dating app with whom he had sex. While he enjoyed himself, he had no interest in reconnecting with her and was annoyed by her repeated calls which he had not returned. He felt justified in not responding so as not to lead her on. He then learned that his ex-girlfriend was accepted to medical school. He texted to congratulate her. When she did not respond immediately, he became angry and texted again to tell her that her lack of response was hurtful. He was shocked when she responded that she thought he was selfish as he had not responded to any of her messages since their break up. He became enraged. He explained that he was offended to be called selfish. Selfishness was bad and he took pride in knowing what was good and bad. He could not tolerate the thought that he had behaved badly. I noted to myself the contradiction in his justification for his lack of response to the women from the dating app and his criticism of his ex-girlfriend's lack of response to him. I did not to share this observation with him as I believed he would experience it as a criticism that could threaten the treatment at that time.

I continued to validate his feelings, often saying that it was understandable he would feel angry when he thinks he has been criticized or devalued by others. He complained that I was not helpful. He said meeting with me had initially made him feel special and lately he was not feeling that way. My validation had felt good at first but now he felt I was normalizing his experience by implying that others may have similar feelings to him and that made him feel average. I suggested that perhaps his suffering made him feel special and by easing it I was taking away his specialness. He acknowledged that he wanted to be seen as special and to be admired by others including me. Soon after this session, he revealed that he had searched for information about me on line. He found an obituary about a family member. The idea that I had was functioning well after this death made him feel weak because he was uncertain he could endure such a loss. When I asked why he searched for the information, he said he felt uncomfortable that I knew more about him than he did about me. I therefore had more power in the relationship because I knew his weaknesses. I clarified that he may feel humiliated by his wish to be helped and also vulnerable to being exploited by me. I was moving gradually from clarifying his experiences to making interpretations that linked his experiences to unconscious fears and motivations. I suggested that perhaps he searched to humiliate or exploit me in an effort to feel less vulnerable and more powerful. He admitted feeling excited while he was searching, certain there was something he would learn that would be humiliating for me. I clarified the reversal of roles, how at times he felt vulnerable and inferior in relationship to someone superior and exploitative and at other times he felt superior in relationship to an inferior other.

He began dating a woman his age who was enrolled in a nearby graduate program for fine art. He admired her creativity and her confidence in sharing her feelings through work that would be evaluated by others. He felt elated in the relationship for a few weeks until she shared details of a past sexual relationship. He was enraged and felt betrayed even though he knew this occurred months before they began dating. His anger felt intolerable and he had difficulty not thinking about her with another man. He thought this other man must have taken advantage of her as he had difficulty accepting that she had been attracted to someone else. He was also angry that she continued a friendship with this man, something he had been unable to do with his ex-girlfriends. He described a dream in which he was back in school and a female professor chose him to come to the front of the class where she kissed him. This led to a discussion about how his self esteem is tied

to being chosen over others. He linked the dream to his desire to be the only man to whom his girlfriend was ever attracted. I suggested that the dream, like the previous dream he had shared, may be also be related to his treatment. Perhaps I was represented in his dream as the experienced teacher who was vulnerable to seduction by a special student? He said it was unclear to him who was seducing whom in the dream. I suggested that at times he may feel like a powerful seducer and at other times he may feel vulnerable to being seduced. When I asked what his thoughts were about being chosen, he said he was often chosen by his mother over his brother.

He shared how special he felt when his mother confided in him about her disappointment in and frustration with his brother and father, something she had done since he was young. Unlike him, his brother had been a rebellious teenager and, to that day, often argued with their mother. His mother also complained about his father's long work hours and lack of emotional availability. As a child, he fantasized that his mother would leave his father and brother, choosing to live with him alone. He expressed his growing frustration that his mother would never overtly confront or criticize his father or brother. Henry recalled that when he was young, his mother was often late to pick him up from school and he worried she would never come. He was always so relieved when she arrived that he never shared his frustration with waiting. Meanwhile, he had a current fantasy of expressing his anger with his father for being selfish and self centered. He described his father's tendency to turn most discussions back to himself and his own life experience, demonstrating little interest in anyone else's point of view. His father, an attorney, was critical of those who worked in finance, describing them as selfish and unjust. His father did a good deal of pro-bono work for families in their community who could not afford legal representation. He was a self made man, putting himself through college and law school. Rather than feeling proud of his father, Henry expressed resentment that his father provided a lifestyle in which they did not have to worry about money. He explained that his father's success deprived him of the opportunity to prove his own success. I clarified that his idea of deprivation seemed to be associated with all or nothing thinking in that only he or his father could achieve success, not both.

He decided to move from his one room in a house to a two bedroom apartment with a roommate. This decision was preceded by visit from his parents in which his father offered to subsidize an apartment for him. Henry suspected his father's offer was not about helping him but rather his own discomfort in Henry's small space. I said that the idea of his father being helpful seemed difficult to tolerate. The next session, he announced it was imperative for him be more independent from his parents so he planned to find a new therapist that he could afford on his own. I suggested that, perhaps, just as it was difficult for him to tolerate his father as helpful, it was difficult to tolerate that I was helping him. He questioned how I could care for him and continue to charge him for sessions. He said if I cared, I would help him for free. I asked if he thought it was possible for me to both care for him and receive payment for my time and expertise, rather than one or the other? He acknowledged that it was possible. I clarified that meaningful relationships can exist with limits. I then reiterated that the experience of being helped by me may feel humiliating and make him to want to leave the treatment. Henry suddenly appeared sad, explaining that it was terribly upsetting for me to understand something about him that he had not realized on his own. He went on to explain that this experience made him doubt his past assessments of others as critical or hurtful. He wondered if his assessments had been wrong.

He was feeling increasingly devalued by his girlfriend who was not quick to respond to his text messages. He was having difficulty sleeping because he was ruminating about her past sexual relationship. He could not help but share these feelings with her, letting her know how her past behavior had hurt him. When they were together, he rebuffed her advances. She told him that she was hurt and frustrated. We discussed his aggressive impulses and all or nothing thinking. He began to recognize how easily he felt devalued in his relationships. As I asked him how he felt when he pushed her away, he admitted to feeling some pleasure in turning the tables on her. This realization led to acute anxiety that he was a cruel and hurtful person. He became depressed and tearful with decreased appetite and early morning awakenings. He felt inadequate around his girlfriend and uncertain how to proceed in the relationship when he has been unknowingly hurtful. He said he was very angry with me for opening his eyes to this possibility and not providing relief for his uncomfortable feelings. I said that I understood why he would feel that way. The following session he

reported feeling better but admitted to worrying that I would terminate the treatment due to his anger at me. I explored his concern that I would react to his anger by cutting him off. He discussed how no one talked about anger in his family. When his parents were angry, they either left the room or talked critically behind the back of the person who angered them. He said that the fact that I tolerated his anger helped him to feel less angry and indicated that I may actually care about him.

He anticipated his girlfriend would break up with him and she did. He alternated between being angry with himself and her. He reflected on past romantic relationships, realizing that he entered each one idealizing the woman and, over time, came to feel generally disappointed when she did not live up to his expectations. He would then feel resentful and criticize her for disappointing him. He expressed some guilt about this behavior. I noticed that he was less grandiose. He articulated his desire to be identified as special and how empty and alone he felt when that did not happen. His mood was low. I validated his distress and suggested that this experience indicated progress in the treatment. I recommended he reconsider meeting with me two times per week. I acknowledged his improved insight into his behavior and explained that increasing the frequency of his sessions would likely increase his rate of progress, making him less vulnerable to episodes of depression. I asked him how he was feeling now about his parents paying for the treatment. He admitted that it seemed insignificant as they had not mentioned it. He had anticipated they would hold it over his head, emphasizing his dependency on them or using it to humiliate him in some way, but that had not happened. I identified the dyad of a powerful, controlling, critical parent and vulnerable, dependent, weak child. I suggested he may feel better if, now that he was working, he contributed to my fee. He agreed and calculated what he could afford monthly before speaking with his father who agreed to pay the remainder owed for twice weekly sessions.

Second Phase: Twice weekly sessions for two years. Soon after increasing the frequency of sessions, there was an increase in the intensity of Henry's feelings about me. We revisited dynamics introduced in the first phase of treatment. He now had an enhanced ability to articulate his anxious thoughts and vulnerable feelings about me indicating a progressive shift from unconscious to conscious awareness. There was an emergence of more variegated transferences. He alternately identified with both sides of two dyads consisting of one more morally superior and critical of the other and one more seductive and exploitative of the other. He discussed feelings of being criticized, devalued and exploited by me which were similar to his feeling in previous relationships with women, including his mother. He felt he could never criticize her for fear of losing her affection. He became acutely angry with me when I billed him for a missed session per my cancellation policy. He said, again, that if I cared for him, I would not charge him. We discussed his difficulty associating a caring relationship with boundaries. He expressed anger when he had to ask me to refill his prescription and shared his thought that I should keep track of his need for refills. When I asked why requesting the refill made him angry, he was able to articulate his persistent self criticism about needing help and his continued belief that he should be able to meet his own needs.

His discomfort in being needy and vulnerable led to doubts about being able to trust me. He shared his continued suspicion that I was withholding key information that would make him feel better and suggested that either I get pleasure from seeing him struggle, or I was not skilled enough to help him. I pointed out his all or nothing thinking that either I have all the answers, or I am unskilled. I also clarified his experience of me as sadistically withholding. He later described his reaction to a group text with his parents and brother in which his parents introduced the idea of selling their home. He had mixed feelings about the home itself, describing his comfort in the familiarity of it and his discomfort in never feeling entirely accepted there. He did not want them to sell yet. When I asked how his family had reacted to his thought about it, he said he had not responded. In fact, he often did not respond to text messages. I confronted the disconnect between his lack of responsiveness and his fear of being excluded or dismissed. He explained that if he was important enough to others, they would continue to reach out. I noted the role reversal in his experience of me as withholding. I identified a dyad in which one was powerful, withholding, dismissive and even sadistic while the other was needy, devalued, submissive and angry.

I called attention to his nonverbal communications. While his awareness of his unconscious motivation to be

admired and powerful was growing, his grooming had deteriorated. He was regularly unshaven and his hair uncombed. He wore the same sweatpants to several consecutive sessions. I pointed out the discrepancy in his physical and verbal presentation. He explained that he was depressed due to his new awareness of his flaws and lacked the energy to dress up for our sessions. I initially presumed that his presentation was a sign that he was becoming better integrated, moving away from grandiose perfectionism (Diamond et al., 2021). However, I experienced it as repulsive and it seemed dissociated from his progress. My countertransference was of being punished and resentful. When I asked what he thought it was like for me to meet with him in that state, he said angrily that as his psychiatrist, I should have empathy for his condition. I shared my appreciation for how challenging it was for him to tolerate his depressed mood and referred back to our treatment contract in which we mutually agreed to show up to each session ready to work. I explained that showing up for repeated sessions so unkempt was dismissive of me and the work we were doing together. Using my countertransference, I came to realize that the underlying reason for his presentation was his resentment of my ability to help him. I suggested that while a part of him may appreciate my help in improving his self awareness, another part may resent it and seek to punish me or diminish my significance. I described a reversal of our roles in the dyad previously described in which he was now powerful and sadistic while I was powerless and devalued.

He expressed anger with me for once again pointing out his flaws. Yet, he returned to the next session dressed neatly. He relayed a dream in which he missed the session and I had called to fire him. He awoke from the dream with anxiety about not being able to meet with me. He said his dependence on me made him angry and triggered critical and devaluing thoughts about me such as the idea that I was not a good therapist. I clarified that his devaluation of others, including me, temporarily made him feel better as he was relieved of his own devalued feelings. I also noted that in the dream, I was the one who was critical and punished him for not being a good patient. This led to a discussion about his projection of his self critical and self punishing thoughts onto others.

He endorsed self-critical thoughts that he was not special or unique enough to sustain my interest. He also said he imagined that, not only was I was critical of his ideas, but he would have to submit to my way of thinking in order for me to care about him. I clarified that on one hand he worried he was not unique enough to sustain my attention, while on the other hand he had to conform to my way of thinking to receive care. He linked this idea to his relationship with his mother who expressed tremendous gratification when he agreed with her. I suggested that he may have difficulty tolerating his own thoughts or feelings when they do not align with his idealized view of himself. He reported difficulty giving up his idealized expectations for himself. I empathized and said that it would be reasonable for him to feel anger and sadness, or even grief, upon giving up exciting, idealized thoughts about himself. He shared a new awareness that as he began to give up his idealized thoughts about relationships, his relationships are less fraught with conflict. However, he complained that without conflict, he sometimes felt bored. He shared his realization that, in the past, he made positive associations to painful experiences and had difficulty placing value on relationships that did not illicit strong, often painful, feeling. He described how he had disliked his high school track coach who was controlling, critical and unsympathetic but did not respect his college coach who, in retrospect, was flexible, supportive and empathic. He explained that the kindness of the college coach made his high school coach's behavior seem cruel. If that was true, he saw himself as naive and weak to have allowed himself to be treated that way. The kindness of the college coach also triggered some awareness of his need to be cared for which made him feel dependent and weak. As a result, he quit the team. He now regretted that he had rebuffed what he needed but understood that he did so because he experienced dependency as a vulnerability.

The nature of his friendships were deepening. He recognized that he had idealized his new roommate when he moved into the roommate's well decorated apartment that was visited regularly by a diverse and fun group of friends. Henry was thrilled to be included but quickly became annoyed by visitors staying late and leaving a mess. He alternated between being angry with his roommate and angry with himself for feeling annoyed. He had difficulty determining what was a reasonable expectation or boundary to request. He withdrew into his room and his roommate predictably began to question if he was okay. Henry was aware that his withdrawal was making his roommate uncomfortable and possibly anxious. He began experiencing

his roommate as needy and weak. However, he maintained his awareness of his tendency to put others down when he felt devalued. He recognized how that type of reaction had led to social isolation in the past. He ended up telling his roommate that he appreciated living there but the late night entertaining was disrupting his sleep. To his surprise, he roommate was apologetic and changed his behavior.

At the same time, he was critical of co-workers who went to happy hour on Fridays. He was initially invited but over time the invitations ceased. He felt dismissed and internally criticized his coworkers, particularly the men, for relying on alcohol to socialize. When I suggested that perhaps he was now considered part of the group for whom the invitation is implied, he realized that he was unaccustomed to feeling included and recognized how he was using a moral high-ground to justify his criticism of others whom he felt had dismissed him. He was also recognizing his rivalrous and competitive feelings with other men. He envied his male coworkers who seemed to effortlessly attract attention from women. His envious feelings made him feel that he could offer nothing of value. He again realized that he had previously leaned on principles of justice to feel better about himself by evaluating himself as morally superior to others. I suggested that his moral superiority may have protected him from his own intolerable, devalued feelings about himself. He agreed and said he also used it to justify not returning calls and texts by finding the other person morally flawed. He felt sadness about his tendency to withdraw from intimate connections due to his need for admiration and his expectation of being devalued. We discussed how that lack of reciprocity prevented him from coming up against the reality that others may not actually disappoint him.

Henry began to re-evaluate his familial relationships. For the first time, he responded to his brother who texted to wish him a happy birthday. His response led to a phone call in which his brother shared his concerns for their mother after she had fallen and broken her leg. They spoke about their parents aging and the idea of selling the family home. His brother encouraged him to call their father who was caring for their mother. They agreed that their father had a tendency to get defensive when he felt criticized or dismissed. Henry recognized that he could relate to his father's reactivity and felt briefly anxious that he was just like him. This led to the idea that he may be like his father in both good and bad ways. Overall, he was satisfied in overcoming his ambivalence in speaking with his brother and was appreciative of their ability to reflect on their familial relationships. Upon his next visit home, he shared with his father his thoughts about changing jobs and he experienced him as attentive and interested. When a member of the community stopped by to thank his father for his help in a legal matter, Henry felt proud of him for what felt like the first time. He also expressed his disappointment in his parents' limitations including their difficulty sorting through clutter in their home. He also acknowledged his effort to keep in mind their strengths, such as their willingness to pay for his treatment. He was recognizing how he had idealized and devalued these primary attachment figures and now had an interest in a meaningful connection with his family.

His increased awareness about his interpersonal dynamics triggered reflections on past romantic relationships with women and how powerless and humiliated he felt when his idealized of thoughts were challenged. As he began to feel better about about himself, he expressed appreciation for my help and remembered how he was incapable of feeling appreciation for past girlfriends. He recalled incidents in which he was devaluing and punishing. He felt guilty and ashamed. He expressed guilt and remorse about his critical and devaluing behavior towards me. Unlike with past girlfriends, he was now able to maintain a friendship with his recent ex-girlfriend. Each time he spoke with her, he realized that he often distorted her comments as criticisms. He was not experiencing the highs and lows he used to associate with relationships. While he missed some of the excitement, he recognized that the stability was more sustainable.

He began rethinking his job and his professional direction. He tolerated his disappointment when he learned he would not receive a raise at work for the next year. He began submitting job applications and expressed regret for not utilizing the career development resources available to him in college. He recognized how his prior low self esteem and critical thoughts about ambition has made it impossible. He expressed a desire to make money and challenged his longstanding belief that he could never be as successful as his father. He found job postings that were well suited to both his interests and skills which he thought did not exist, expecting to sacrifice one for another. He contacted his both his undergraduate and graduate career office

and began networking with alumni. He recognized that he would not have been able to engage in such ways months ago. He also recognized his tendency to undervalue his qualifications. He decided to apply for and was offered a managerial position at a local nonprofit organization and was able to negotiate for a higher salary.

Outcome and Prognosis :

As the start date for his new job approached, Henry realized that he would not be able to keep his current session times with me and revealed his thoughts about ending his treatment at that time. We talked about past feelings of disappointment, anger and anxiety at times of separation such as when I took vacation. His reaction to my absence had evolved to feelings of sadness or longing as well as relief that he could hold onto generally good feelings about me and manage well on his own. As we worked through the termination phase of his treatment, Henry safely tapered off his antidepressant medication. He planned a camping trip with friends and, for the first time, said he felt genuine, mutual collaboration and appreciation between them. He was expanding his diet and tolerating any mild adverse reaction without significant discomfort or distress. He got a new haircut, revealing his full face and said he did not know why he worn it over his eyes. When I suggested that maybe he had been hiding a part of himself, he laughed as he nodded in agreement. He joined a local running club where he was meeting people with a common interest in fitness. He attended the orientation for incoming students to his graduate program and, when listening to his peers talk about socioeconomic diversity, he recognized that he was able to hold multiple viewpoints in mind.

Henry shared his satisfaction in the improvement in his sense of himself and the strength of his relationships, which he attributed to his treatment. He said that, in the past, he had to rigidly prove to himself that he was a good person and how he now believed he was a generally good person with reasonable flaws. He expressed sincere appreciation for my help and I provided reassurance that he could reach out to me as needed. He returned to see me about six months after he left treatment to let me know that he had decided to return to the West Coast to live near his family. He felt he was able to tolerate the imperfections in his familial relationships without a desire to change them and had a deeper understanding of the complexities of those relationships. He was sad about leaving me and his current community but felt confident that he would keep in touch. He was excited about reconnecting with his brother and several college friends who had recently moved west. He shared reasonable and hopeful expectations about his future.

Clinical Practice and Summary:

What evidence do we have that TFP is effective for NPD and what in TFP-N helps patients with NPD?

As with other treatment modalities, including short term psychodynamic psychotherapy, Dialectical Behavioral Therapy, mentalization-based therapy and schema-focused therapy, there are no randomized controlled trials (RCTs) of TFP for NPD only (Diamond et al., 2022). However, in two RCTs (Clarkin et al., 2007; Doering et al., 2010) and one uncontrolled trial (Clarkin et al, 2001), TFP was shown to be effective treatment for patients with combined BPD and NPD. TFP has been found to improve mood symptoms such as depression and anxiety as well as psychosocial functioning, and impulsive aggression (Clarkin et al, 2007) and suicidality and self-injurious behaviors (Clarkin et al 2001; Doering et al., 2010) in patients with severe personality disorders. These improvements benefit patients with NPD who often have co-morbid anxiety and mood disorders as well as substance use disorders (Hörz-Sagstetter et al., 2018). Findings of studies on patients with co-occurring BPD and NPD indicate that TFP can address the specific needs and clinical challenges presented by individuals with NPD including intolerance of dependency and fear of exposure, fluctuations between grandiose and vulnerable mental states, aggressive reactions to criticism or challenge of grandiose self beliefs, and high rates of drop out (Diamond et al., 2022). More specifically, TFP improves both attachment security and reflective functioning, the capacity for mentalization in the context of attachment relationships, (Levy et al. 2006; Diamond et al. 2014; Buchheim et al., 2017). These changes in mentalization and internal representations of attachment relationships are important because, due their limited capacity for empathy, patients like Henry with NPD or pathological narcissism have difficulty forming and sustaining attachments as well as differentiating between their own and other's mental states (Diamond et al., 2022).

Finally, through case material such as this report, the effectiveness of TFP to treat NPD is consistently demonstrated (Diamond & Hersh, 2020; Diamond et al., 2021).

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