Narcissism with Jonathan Shedler

Nha Nguyen, Catalina Baas, Jorge Salazar, Jonathan Shedler, PhD, David Puder, M.D.

In this episode of the podcast, we are joined by Dr. Jonathan Shedler to discuss narcissistic personality disorder. Dr. Shedler is a psychologist, consultant, clinical educator, researcher, and author with over 100 scholarly publications. His article, *"*The Efficacy of Psychodynamic Psychotherapy," has garnered worldwide recognition for establishing evidence-based support of psychodynamic psychotherapy.

Narcissism in Pop Culture

It has been a long-standing tradition in social media and pop culture to label people as "The Narcissist" if they have mistreated, gaslighted, or victimized others. Pop culture tends to view narcissism through one lens. In this case, it is the borderline personality organization/malignant narcissism lens, which is a pop-culture version of the complex, multi-headed hydra that we call narcissistic personality.

In pop culture, narcissism is being used as an umbrella term for all bad conduct. In the psychodynamic tradition from which the term arose, narcissistic personality exists at different levels on a continuum of health-pathology: at a healthier, neurotic level of personality organization and at more disturbed, borderline and psychotic levels of personality organization. The psychoanalytic tradition of narcissistic personality is lost to the pop culture definition that all narcissistic individuals are arrogant, self-inflated, exploitive people, when that is not at all the case.

If we go deeper behind an overt narcissist's facade of superiority, there is great suffering. For example, individuals with narcissistic personality are likely to struggle with feelings of emptiness, meaningless, and inadequacy, and suffer from their inability to develop and keep meaningful relationships. But in social media and pop culture usage, the term is often used as little more than a way to vilify.

Narcissistic Personality

Narcissistic personality is characterized by contradictory, simultaneous feelings of superiority and grandiosity and feelings of vulnerability, emptiness, and inadequacy. In overt narcissism, we tend to see one side of this inner contradiction: the sense of self-importance and entitlement. Internally, the person is torn between feelings of superiority and entitlement and feelings of emptiness and deep unworthiness. The overt grandiosity defends against and masks the underlying feelings of emptiness, inadequacy, and fragility. The person works continually to shore up a fragile sense of self, and make use of others to support this effort. They need others as an audience, to witness and affirm their importance, and this need can override the awareness that those recruited as their audience are also human beings with their own emotions, needs, vulnerabilities, and experiences. This tends to preclude developing the kind of

mutual, genuine relationships that give life a sense of meaning and purpose, that could counteract their inner sense of emptiness and deficiency. The result is that they can be surrounded by admirers yet starve emotionally in a sea of plenty.

There are two main manifestations of narcissism: grandiose (or overt) narcissism and vulnerable (or covert) narcissism. People with grandiose narcissism present themselves as self-important, entitled, and superior. Their narcissistic defenses are effective in keeping their feelings of inadequacy at bay, at least most of the time. Underneath the overt self-importance, however, lie deep feelings of fragility and inadequacy.

In vulnerable narcissism, in contrast, the narcissistic defenses against inadequacy fail. Rather than experiencing themselves as grandiose, they experience themselves, and come across to others, as deflated, self-critical, and beaten down by life. They often present in clinical practice as depressed. Beneath their suffering and self-criticism, we find that their inner life is dominated by fantasies of importance, success, and glory. They are the central characters in their internal narratives, unappreciated, unrecognized, and denied their rightful place in the world. At different times, the same individual may present as either a grandiose or vulnerable narcissist, depending on how well their defenses are functioning and how well the external world is cooperating with those defenses. Both manifestations of severe narcissism preclude developing and maintaining meaningful and lasting interpersonal connections. Ultimately, their lives feel painfully empty.

The expression of grandiose and vulnerable narcissism heavily relies on psychological defenses. Kampe et al., in their 2021 study, found that both types are significantly associated with neurotic and maladaptive defense mechanisms such as reaction formation, acting out, splitting, and passive aggression. However, unlike the vulnerable type, the grandiose type was also significantly associated with some adaptive defense mechanisms, including rationalization, anticipation, and dissociation (Kampe et al., 2021). Adaptive defense mechanisms help individuals cope with unpleasant emotions and are associated with a healthier mental state. The negative association with adaptive defense mechanisms may help explain why vulnerable narcissism is more often associated with observable psychological distress.

Levels of Personality Organization

Based on a theoretical framework developed by psychoanalyst Otto Kernberg, personality disorders fall along a continuum of severity with three main levels of organization: neurotic, borderline, and psychotic (Kernberg, 2004).

Neurotic personality organization is the least severe and includes an intact sense of reality, use of mature defense mechanisms, and an established sense of self. It is a healthier version of narcissism that is actually vital in society. They can be visionaries, innovators, and charismatic leaders. We often see these higher-functioning narcissistic individuals as the tech moguls or

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CEOs of successful, powerful companies. They have grand visions and fantasies and the drive and confidence to make them a reality. Like all narcissists, they have an inflated self-image, but this exaggerated confidence allows them to take risks and, with confident perseverance, build something of genuine and lasting value. With healthy narcissism, grandiosity is connected to reality: in other words, the recognition they crave is based on actual merit, not defensive fantasy. Also, their capacity for attachment is largely intact. Unlike those at more severe levels of disturbance, they are capable of caring, empathy, and love.

Borderline personality organization is a more severe level of disturbance. Reality testing is generally intact—that is, the person is not delusional—but immature and highly costly defenses distort perceptions of both self and others and cause substantial impairment in functioning. As a general rule, when narcissism is pronounced enough to warrant a DSM diagnosis of narcissistic personality disorder (NPD), the person is functioning at a borderline level of personality organization. The central defenses at this level of organization is splitting, or dissociation of good and bad feelings, projection, and projective identification. The person cannot see themselves or others in shades of gray, recognizing that humans are necessarily a complex mix of good and bad qualities, virtues and shortcomings. Instead, they see people in black-and white categories of good and bad, heroes and villains, saints and sinners.

In the case of the borderline-level narcissist, the defense of splitting takes the form of ascribing all good and admirable qualities to themselves and projecting their limitations, failures, and bad feelings onto others. Thus, they experience themselves as all-good and all-important while perceiving others as weak, inadequate, and inferior. At this level of personality organization, defensive grandiosity distorts realistic self-perceptions. The person expects recognition and rewards for their unique talents and achievements, irrespective of whether they are real or merely imagined. They expect accolades and preferential treatment, earned or unearned. Kernberg refers to this defensively distorted self-concept as the “pathological grandiose self” (Kernberg, 2007). It is maintained by dissociating and projecting negative experiences onto others, who are the devalued. Projective identification takes the defense of projection one step further, by treating others in ways that actually induce or elicit the unwanted feelings they have projected with such vehemence.

Most social media and pop-culture depictions of narcissistic personality are, in fact, descriptions of a narcissistic personality style at a borderline level of personality organization. For example, “gaslighting”—thought by social media pundits to be a central feature of narcissism—most often results from the borderline-level defense of projective identification, which has the effect of distorting the other person’s perceptions and experience of self. Some clinicians have described it as a feeling of having their minds “colonized’ by something alien.

A still more severe and destructive version of narcissism is termed *malignant narcissism*. Always organized at a borderline level of personality organization, malignant narcissism is narcissism suffused with sadistic aggression. The capacity to attach to and care for others is

severely damaged, and interpersonal relationships are dominated by aggression and hate. Others exist merely to be used, exploited, and coldly discarded. Mere self-importance isn't enough for the malignant narcissist; they seek the defeat and obliteration of others. At this level of functioning, malignant narcissism shades into frank psychopathy. Pop-culture and social media portrayals of "narcissism" often fail to distinguish narcissism from borderline personality organization and psychopathy.

Origin and Treatment of NPD: Kohut vs. Kernberg

NPD is a complex disorder that has many conflicting ideas about its origin and therapeutic treatment. The most significant arguments surround the theories of Kohut and Kernberg.

Kohut believed that NPD was a result of a developmental deficit; in childhood, narcissistic patients failed to develop a stable identity or capacity to internally regulate their own self-esteem. Consequently, they rely on others for external validation (Russel, 1985). Recognizing this, Kohut advocated for treating narcissism with empathy, understanding, and mirroring. He thought this form of therapy could allow narcissistic patients to resume the developmental trajectory and thrive. In contrast, Kernberg explained narcissism in terms of object relationships theory. He believed narcissism developed as a defense in response to parents who made the child feel inadequate and unloved. He recommended that therapists confront narcissistic patients about their grandiosity and unravel their defenses against feelings of inadequacy.

Research on Transference-Focused Psychotherapy with Emphasis on Changing Reflective Function and Attachment

Transference-focused psychotherapy (TFP) is a twice-weekly psychoanalytic psychotherapy most commonly used in the treatment of borderline personality disorder. It utilizes the patient-therapist relationship to help patients with identity consolidation, emotional regulation, and interpersonal functioning (Levy et al., 2019). TFP has shown effectiveness in treating borderline personality disorder, in part, through improvement of attachment style and reflective function.

Reflective function is the ability to understand oneself and other people with respect to the thoughts, feelings, desires, and intentions that drive behaviors. Rather than taking behaviors at face value (for example, a child throwing a tantrum), someone with intact reflective function is able to envision the underlying mental state (the child is tired and grumpy). Reflective function is

thought to be critical to proper social functioning, and impairments of this ability have been associated with a poorer state of mental health (Anis, 2020).

Although TFP has primarily been studied for borderline personality disorder, similarities in the underlying pathology (especially attachment style and reflective function) suggest TFP may also be a useful treatment approach for narcissistic personality disorder (Diamond and Hersh, 2020).

Research on Transference-Focused Psychotherapy in BPD

In a randomized-controlled trial conducted by Levy et al., “Changes in attachment organization and reflective function were assessed as putative mechanisms of change in 1 of 3 year-long psychotherapy treatments for patients with borderline personality disorder (BPD)” (2006). In this study, ninety patients diagnosed with BPD were randomized into three treatment groups: transference-focused psychotherapy, dialectical behavior therapy, or a modified psychodynamic supportive psychotherapy. To assess attachment organization, the Adult Attachment Interview and the reflective function coding scales were used. The study found that patients’ narrative coherence and reflective function can increase by participating in one year of intensive transference focused psychotherapy. In addition, the authors found that “patients treated with TFP evidenced significant increases in [reflective function], attachment coherence, and rates of being classified as secure with respect to attachment as compared with the other treatment conditions” (Levy et al., 2006). Overall, the study concluded that TFP is an effective treatment for BPD and is more successful than dialectical behavior therapy and supportive psychotherapy in changing attachment.

A separate publication, which appears to evaluate the same study groups as Levy et al., looked at the effects of TFP, dialectical behavior therapy, and psychodynamic supportive psychotherapy on “suicidal behavior, aggression, impulsivity, anxiety, depression, and social adjustment” (Clarkin et al., 2007). It was found that TFP and DBT improved suicidality, while TFP and supportive psychotherapy improved both anger and impulsivity. TFP was the only method significantly associated with improvement of irritability and verbal or physical assault.

In a year-long, randomized-controlled trial, 104 female outpatients were treated with either TFP or by a community psychotherapist in order to “compare transference-focused psychotherapy with treatment by experienced community psychotherapists” (Doering et al., 2010). The study found that both treatments significantly improved depression and anxiety; however, TFP improved general psychopathy while treatment with the psychotherapist did not. In general, TFP was shown to be superior to treatment by experienced community psychotherapists in treating BPD and reducing suicidality and psychiatric inpatient admissions.

A 2015 randomized-controlled trial presented by Fischer-Kern et al. used a sample of 104 patients with BPD to evaluate changes in reflective function. Results suggest improvements in reflective function for those treated with TFP within one year of treatment, while the group treated by experienced community therapists showed no improvement.

A 2017 study by Buchheim et al. compared patients undergoing transference focused psychotherapy and patients seeing experienced community psychotherapists (ECP). They aimed to assess changes in attachment representations, focusing on narrative coherence and resolution of unresolved attachment. Coherence refers to the connection, consistency, and logical relationship between different parts of discourse, where thoughts are clearly related and adapted to the context (Main and Goldwyn, 1998). The results showed significant improvements in attachment security and unresolved trauma within the TFP group, but no significant changes within the ECP group. The coherence scale showed significant improvement within both treatment groups, but the improvement was considerably higher in the TFP group. The between-group difference was also significant; the ECP group had a small Cohen's effect size (d=0.18), and the TFP group had a large effect size (d=1.27).

The 2017 study confirmed previous findings that TFP is better at transitioning individuals from insecure to secure attachment. However, it also revealed a new finding that TFP can lead to a change from unresolved to organized attachment, which is significant for patients with a history of severe maltreatment, abuse, and loss. The shift from insecure to secure attachment status suggests an enhancement in “coherence, attachment-related autonomy, and flexible integration” (Buchheim et al., 2017). TFP, with its structured and emotionally intense approach, creates a safe space for patients to reflect on their attachment patterns. It facilitates integration of polarized emotions, as well as improvement of the understanding of oneself and others, to achieve a more coherent mental state with potential for long-lasting benefit (Buchheim et al., 2017).

Research on Transference-Focused Psychotherapy for NPD

A 2017 publication by Stern et al. presented a case example where TFP was used to treat an individual with narcissistic personality disorder. The authors emphasized the importance of “establishing a viable treatment contract, setting the tone and focus of the treatment, and establishing the treatment as an anchor in the patient’s life” early on in the process. They stated that the early stages of therapy can be challenging to work through but, eventually, the patient can be brought to a more exploratory state of mind where they are more receptive to therapeutic reflection and analysis. Eventually, patients become more tolerant of the “negative self-experiences they had projected onto the outside world, while also tolerating more realistic, imperfect representations of self and others” (Stern et al., 2017).

In their 2020 article, Diamond and Hersh describe a treatment model for TFP for narcissistic patients. They cited examples of this method in clinical practice. The first step is contract-setting, which establishes the roles and responsibilities of the patient and therapist. The next stage involves defining and exploring the patient's dominant object relational dyads. Next, the therapist must identify role-reversal. The narcissistic patient may perceive the therapist as devaluing them and respond by devaluing the therapist through words or actions. As the patient becomes more aware of internally fluctuating between grandiosity and devaluation, they can work toward improvement. Finally, the later stages of TFP involve working through the patient's narcissistic defenses with the goal of attaining a mature, stable sense of self (Diamond and Hersh, 2020).

Transference and Countertransference in Narcissistic Personality

The therapeutic relationship feels significantly different with narcissistic clients than with clients that are not afflicted with NPD. Therapists frequently observe a resistance in narcissistic patients to reciprocate efforts to delve deeper into their psychological state. For narcissists, transference is expressed in the form of devaluing and idealizing. This transference can be explained psychoanalytically: "Rather than projecting a discrete internal object such as a parent onto the therapist, they externalize an aspect of their self" (McWilliams, 2011). In other words, the narcissistic patient projects their devalued or idealized self onto the therapist.

When therapists are devalued by NPD clients, they face numerous accounts of disparagement and belittlement. In doing this, patients are bolstering their grandiosity by flaunting their superiority or associating with their clinician who they view as admirable. In other words, when devaluing, a narcissist displays feelings of self-importance by treating their clinician as inferior. By contrast, in terms of idealization, a narcissist overvalues the therapist and feels special due to their association with the therapist. As a result, "The therapist…becomes a container for their internal process of self-esteem maintenance" (McWilliams 2011). With both devaluation and idealization, narcissists fail to consider that therapists, like all people, have their own challenges, attributes, and feelings. They are preoccupied with viewing therapists through a lens that serves their own purposes.

In response to the transference, therapists often experience countertransference manifesting as feelings of boredom, disengagement, or anger. These reactions can be attributed to the dehumanizing effect they encounter when treating narcissistic patients. In fact, therapists often feel as though they are invisible to the client. "A typical comment about a narcissistic client from a therapist supervision: 'She comes in every week, gives me the news of the week in review, critiques my clothing, dismisses all my interventions, and leaves. Why does she keep coming back? What is she getting out of this?' " (McWilliams 2011). Despite the instinctive reactions of emotional withdrawal or retaliation when faced with devaluation and idealization, effective

therapists are adept at exercising restraint, choosing instead to process their own emotional responses in therapy or supervision.

It is crucial to highlight that the primary aim of a narcissistic client's expression of transference, whether through devaluation or idealization, is not to assign positive or negative attributes to the therapist themselves, but rather to satisfy their narcissistic needs. Understanding this enables the therapist to develop a productive countertransference that positively contributes to the client's therapeutic journey.

Applying Countertransference

Treating patients with NPD can be very taxing, as the transference can elicit strong negative feelings. As previously mentioned, the natural reaction is to disengage and retort, but it is important to be attentive to the countertransference evoked.

Therapists must be fully aware of the transference and countertransference environment with narcissistic patients. What interactions are present that are drawing out these emotions? Instead of feeding into natural instincts, what can be addressed interpersonally? What does this countertransference divulge about their behavior? How can this be tied into their reason for therapy? Through this approach, the therapist can harness countertransference as a tool, sparking introspection in the narcissistic client, thus catalyzing their journey towards self-acceptance and diminishing the propensity to belittle and demean others.

By achieving this, we would simultaneously work towards one of the primary goals of therapy, which is to address the patient's defense mechanisms that hinder their ability to perceive the therapist as a complete individual. Once this objective is accomplished, it significantly increases the likelihood of the patient appreciating others as individuals and, as a result, developing the ability to foster healthier relationships.

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