

Narcissistic Personality Disorder

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1. Introduction

I will present a case of narcissistic character pathology that is rather un(proto)typical. It is well known that in the psychoanalytic treatment of narcissistic psychopathology there is a huge difference between the approaches of Heinz Kohut and Otto Kernberg. The first emphasises the importance of fixation in narcissistic development. He thinks narcissism evolves along separate lines. Pathological narcissism is the result of empathic failure. The infantile and grandiose self wasn't tamed by optimal frustration. There are typical narcissistic transferences like the idealising, mirroring and merger transference and the psychoanalyst adopts an empathic and supportive stance, considerately sharing the unavoidable narcissistic impingements. For Kernberg the grandiose self is a defensive formation against dependency, oral rage and depression. Primitive defences are to be confronted and interpreted inspired by egopsychological, objectrelational and kleinian analysis and with strong emphasis on the negative transference. As is so often the case possibly they are talking about altogether very different patients. Kohut worked in a classic psychoanalytic setting. In his work Kernberg is more engaged with psychiatric patients. I guess we are all really interested in the therapeutic approach Prof Adler advises for the patient I will discuss now.

B is a 32 year old young man, the first-born of four children. At the start of his treatment he lived a socially marginalised life, without any contact with his 60 year old father, a retired salesman, nor with his two younger brothers and sister. He had no income whatsoever and due to his chaotic lifestyle and his administrative carelessness could not benefit from social security services, nor from any health insurance. His mother, a nurse, died an untimely and unexpected death by leukaemia when he was 10 and half years old.

His features are puerile and slightly feminine, which gives him an androgynous outlook. His talking is voluble and somewhat pedantic. He speaks of himself with considerable liveliness, interest and fascination, all too well aware as it seems of his own memorable existence as if he were a genuine literary character. He seems eager to please and to enchant, but when he talks about his sporadic aggressive outbursts he clicks his fingers quite impressively so that one becomes conscious

of an enormous destructive potential that lies dormant (but easy to ignite) beneath his cuddlesome behaviour. He himself appears to consider this as something alien. Something that arises instantly, without notification. It erupts out of the blue, *ex nihilo*. In this sense he pleads: not guilty.

First I will describe our first findings within the first new contacts. I will proceed by giving an account of his psychotherapeutic process and his evolution.

During the period I have known him the therapeutic wanderings of this patient were situated in different settings. During the first five months he was treated in a psychiatric hospital ward in the far west of the country. The ward is structured following psychotherapeutic community principles i.e. psychoanalytic psychotherapy not just within but to a large degree via, by means of the psychotherapeutic milieu. The therapeutic programme is centred on psychoanalytic group psychotherapy sessions of 90 minutes twice a week in his case with myself as the psychotherapist.

Then followed a three month period of ambulatory individual psychotherapy with me. Afterwards came a two month period of institutional psychotherapy in another psychiatric hospital ward, this time in the far east of the country. My distinguished colleagues from this morning will recount their impressions about this period. Afterwards and up to now he returned for psychotherapy to me.

2. *First findings*

The patient was sent to me by a colleague about 70 miles away who was at pains in trying to convince me that this patient's problems constituted an indication for residential psychoanalytic psychotherapy. This in spite of his having assaulted a nurse with a stick and thereby breaking her arm. In his terms the patient was a homosexual prostitute eager for insight and motivated for change and I remember thinking this patient appeared to be able to generate substantial positive countertransference.

He had been admitted in our hospital at the age of 16 for one week and he declared his back-to-the-roots like return (he was also born in our side of the country and his father still lived there) so many years later to be an indication of his desire to go in-depth and of his willingness to engage in the challenge of change. Indeed, he considered the past 15 years or so to be one long survival route, full of blind action and without any trace of real progress. It had led him to various alternative communities here and in the Scandinavian countries, where he had sought and temporarily found warmth and affection in usually just marginally structured surroundings. In this context it is noteworthy that in the first community meeting he attended he seated himself in the front row on the floor and created some upheaval and annoyance by behaving as if our ward were one more holiday camp.

During these years he had managed to earn a living as a homosexual prostitute or within homosexual escort services which had for long periods of time allowed

him also some –as he now realised- illusory gratification of affective, sexual and/or narcissistic needs. He vividly describes himself sitting in the show-windows of brothels and feeding himself with the adoring and/or desiring glances of his clients as if this gave him the idea of being a god-like creature. In his own words for the very first time he felt genuinely successful and powerful.

The fact that a few years before this hospitalisation he began baking sandwiches in a handicraft fashion and that he started to sell them for little so-called macrobiotic shops was for him the beginning of the end of this Ice-Age in that it followed up the macrobiotic interests of his father and of a substitutive parent figure from his puberty. After several hospitalisations all over the country that kept ending up in a dismissal for disciplinary reasons he landed here.

In our first contact he complained of a sense of solitude and abandonment, as well as an inner void, an emptiness, smiling however when doing so. His father he portrayed as a weak figure, insufficiently available as a solid educator, always occupied with his job and his shop and not having ‘a good heart’. He claimed at first not to have any childhood memories, especially not from before his mother’s death. Nevertheless he quickly provided some significant information albeit by what he himself called ‘a reconstruction’ i.e. a theory devoid of feelings. Consciously he possessed no image of his mother, had no idea what she looked like but he told me she was very caring and protective. That he had been spoiled by her. That she gave in to him behind the back of his father. That having had several miscarriages she was extremely pleased with his birth. There were lots of photographs indicating in his opinion an exaggerated adoration. That –in short- he seemed to be his mother’s darling. After her death his father was depressed and bereaved. Her loss was not much talked about. Immediately afterwards our patient developed a period of excessive, almost obsessive cleaning as if to eliminate all negative feeling. He became more bossy, dominant than he had been before and he tried to assume a symmetrical position towards his father, wanted to sleep with him and run the household, be a grown-up.

In his own words he identified himself with the mother and he defied all authority. His father wasn’t able to handle him (nor the other children) and it was the start of countless boarding-schools, homes, foster parents, youth protection interventions etc. leading to repeated failure due to insubordination, itself the result of what he increasingly considers to be his stubborn overestimation of his own capacities.

He considers himself still to be a little boy, who –in his own words- kicks on receiving a lolly. He is constantly in search of fusion or merging with a mother figure, regressing thereby to the bliss of an infant at his mother’s breast. He sleeps with a teddy-bear, wants to be on somebody’s lap (not only figuratively, but also literally) experiencing on those occasions ‘a spiritual orgasm’. In his life he recognizes a pattern of exclusive, strongly idealised dyads with older men who – in a way- for the time being adopted him like some sort of ‘lost son’ and who as a kind of combined parent figure took care of him and managed to keep him fairly ‘under control’. In his own words they meant everything to him while he himself felt very important to them. Apart from these idealised or idyllic relations there always was a fair amount of hostility towards ‘thirds’.

On the other hand he realises having great difficulties with laws, rules and authority in general. He can't take 'no' for an answer. There is also some awareness that he can be extremely critical of others whereas he himself easily feels injured and hereby experiences often uncontrollable fits of rage.

One more thing for now: the Szondi test (a projective psychoanalytical test) was implemented during the first few weeks of his hospitalisation and revealed a so-called hystero-epileptical structure. In his case the test-material revealed three main components: very strong paroxysms of patricidal impulse (like one of the Karamazov-brothers), the urging presence of a strong, raw, unmitigated destructive drive and strong oral '*Suchtigkeit*' due to (fear of) loss of her primal object.

Needless to say that after having instated a very explicit 'no violence' besides the usual rules I gave in to my psychotherapeutic appetite and we got 'on the road' together.

3. *Psychotherapeutic process and evolution*

From the beginning there was a good rapport between the patient and me. There was a strong positive transference that was and remained up to now somewhat idealising. Also he elicited in me considerable positive –I dare to say almost adoptive- countertransference. It was as if we formed a Madonna-with-Child like couple, characterized by reciprocal rapture.

The fact that I myself am an only child and have experienced a very marked narcissistic symbiosis with my mother must have facilitated some mirroring. In psychotherapy he was and is motivated, introspective, trying to be authentic, plastic and often quite original in his expression. Considering his previous history of obstinate and often illicit maladaptiveness I had and still have a genuine respect for his psychotherapeutic endeavours. I have tried to offer him a firm holding, empathically inspired and formulated confrontation, clarification but also interpretation and construction. My aim has always been mainly towards differentiation and integration.

Within our psychotherapeutic community he manifested himself at first as a motivated patient. He participated regularly in the therapeutic programme, talked openly about his problems and had a constructive attitude. Some of the themes that he touched upon were: his solitude, the futility of his existence as a tramp, pornographic obsessions (to fill the inner emptiness), the loss of his mother, the relations with his family, how he could learn to keep and entertain a lasting relationship, his difficulties with rules and authority, his questions about masculinity and femininity, his destructiveness and so forth. There were moments when he felt very guilty, inferior, depressed, anxious. Moments also that he longed to be cuddled.

After a while however his behaviour became very disturbing. He developed his own rules, criticized fellow patients and staff members in a very harsh, cruel and

condescending, even humiliating manner. He was big-mouthed, at times offensive and menacing with physical violence. He got into conflict with everyone, provoked and (apparently deliberately, sadistically) injured others. He gets isolated, flights to the neighbouring ward with its 60+ population. He chooses the therapy he wants to follow, plays the truant, leaves the hospital without permission etc. On the one hand there is a lot of entitlement, captivating attention-seeking behaviour. On the other hand he feels permanently wronged, underprivileged. Everything is his right, nothing his duty.

The fact that we had allowed him to follow an apprentice course as an assistant-cook and that he later went to work in the kitchen of a local restaurant because of his extreme poverty undoubtedly undermined the holding function of the ward environment and was –retrospectively considered- our mistake.

Meanwhile within psychotherapy (and to some extent in the expressive therapies as well) he predominantly remains constructive, introspective, autocritical, trying to analyse both his positive and his negative transferences. As I embodied not only the psychotherapeutic but also the psychiatric function, paternally guarding the holding environment of the ward, he seemed almost to enjoy my confrontations and limit-setting.

After a two week time-out for disciplinary reasons he resumes somewhat more constructively but despite continuous efforts to enhance the containment and holding capacity of the team (in which he evoked forceful negative countertransference because of his antisocial tendencies) I had finally to dismiss him from the hospital because of considerable material damage he had caused in a fit of rage and because one could no longer handle his terrorizing and verbally life-threatening abusiveness and tyranny in the ward.

After an attempt to transfer him to a University psychiatric hospital for continuation of residential psychotherapy, an attempt that fails because one understandably fears renewed antisocial destructiveness, I make the necessary arrangements to see him regularly on an ambulatory basis.

In my view of the moment he is a man with two faces: on the one hand there is a pattern of nearly exclusive relations with (anatomically masculine) motherfigures in whom he elicits adoptive countertransferences and with whom he establishes a merger. In his own words: X used to say I was ‘in’ him. On the other (antisocial) hand he is the survivor/stray cat who can not or will not adapt to rules, laws (the father). Aspecific Ego-weakness but also some primitive defence mechanisms like idealisation, denial, projective identification and splitting are paramount in an otherwise psychologically sophisticated patient who in my opinion had already made real psychotherapeutic progress towards ego-strengthening, object-constancy, taming of grandiosity and integration. My diagnosis at the end of this hospitalisation: narcissistic personality disorder with borderline ego-functioning displaying antisocial traits.

After his dismissal he finds an interim job in a chocolate factory, rents a small apartment. He spends several weekends with his father, has renewed contact with his family, spends his other weekends in an alternative community, establishing

once more a narcissistic object-relation with a priest. His social security status and health insurance had been regularized, so I requested him to pay a normal fee. Coming by train and by bus from the other side of the country for once a week session together with some support from a social worker near his residence proved not enough, so I arranged for admission in the aforementioned psychiatric hospital in the far east. My colleagues will/have elucidate(d) this period a little further.

After this treatment he returns for once a week psychotherapy. He restarted a small handicraft sandwiches business, bought a car and an oven. He has had a girl-friend with whom there was no merger, but with whom he had for some weeks a sexual relationship. And he developed a courtly love for a lady who –by the gentleness of her touch and by the tone of her voice- in his words ‘moved and captured him deeply’.

He always was and still seems excessively glad to see me, the atmosphere being one of wine and roses. Negative feelings continue to be located solely outside of the transference situation.

More than a year after we first met he feels somewhat more in control, autonomous and in tune with outer as well as inner reality. Subjectively and objectively his frustration tolerance and impulse control have improved. He feels responsible and begins to develop at least some empathic capability. In his own words: after 30 years on the throne and being in fact an unmanageable boy, I long to be an ordinary guy...