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THE DEPENDENT SELF IN NARCISSISTIC PERSONALITY DISORDER IN COMPARISON TO DEPENDENT PERSONALITY DISORDER: A DIALOGICAL ANALYSIS

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ABSTRACT. Many manifestations of human dependency are adaptive, such as looking for proximity, care, and support when in distress, or establishing stable bonds in which others are perceived as a safe haven that can shield us against many difficulties and dangers. In spite of these adaptive manifestations, dependency can be maladaptive. Psychiatric classification has generally labelled dependency "Dependent Personality Disorder", but empirical evidence supports the notion that maladaptive dependency symptoms are positively related to the majority of DSM-IV PDs from all three clusters. A disorder in which only a few thinkers have noted the presence of severe aspects of unhealthy dependency is Narcissistic Personality Disorder. This is completely lacking in the DSM description of the disorder. In this paper we highlight maladaptive dependency features in NPD and comparing them with unhealthy dependency in DPD. Our analysis will make use of diary and session fragments involving patients with severe manifestations of both NPD and DPD, and will be carried out within the framework of Dialogical Self Theory.

Human beings have an innate need to establish and maintain dependency bonds, largely through the activation of the attachment system. This drives them during their life cycles to look for the protection and proximity of another, whom they look on as stronger and reassuring (Bowlby, 1988). Many manifestations of dependency are therefore adaptive, such as looking for proximity, care, and support when in distress, or establishing stable bonds in which others are perceived as a safe haven that can shield us against many difficulties and dangers. In spite of the adaptive value of relying on others, dependency can be maladaptive. Bornstein (2005) distinguishes between unhealthy and healthy dependency: the former characterized by intense, under-modulated strivings, exhibited without the necessary reflexive effort across a broad range of situations and the latter by strivings – even intense – exhibited selectively (i.e. in some contexts but not others) and flexibly (i.e. in situation-appropriate ways).

Persons exhibit dependent behaviours because these are rewarded, were rewarded or – at least - are perceived by them as likely to elicit rewards (Dollard & Miller, 1950). Cognitive models of pathological dependency focus on the ways in which

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a style of thinking and processing information helps foster and maintain dependent behaviour. Over time persons develop internal working models of attachment (Bowlby, 1988), which are often cognitively and consciously represented, thus creating images such as *self as ineffectual and weak* facing a *powerful and critical other*. When schemas like this become generalised and suppress other representations such as *self-as-an-effective-agent* and *other-as-a-supporter*, a person can over-rely on dependency on others and generate dependency-fostering automatic thoughts, such as "I can't handle this on my own" and "I'll fall apart completely unless someone helps me" (Beck, 1976; Beck & Freeman, 1990). Bornstein (1992, 1993, 1996) described an interactionist model of unhealthy interpersonal dependency, according to which dependency consists of four primary components: cognitive, i.e. a perception of oneself as powerless and ineffectual and of others as powerful and potent; motivational or a strong desire for guidance, approval and support from others; affective, i.e. becoming anxious when required to function autonomously; and behavioural, displayed in the use of an array of relationship-facilitating self-presentation strategies to strengthen ties to others, such as ingratiation and supplication. Psychiatric classification has generally labelled dependency "Dependent Personality Disorder" (DPD; American Psychiatric Association, 2000), in which the fundamental dimension is a pervasive and excessive need to be taken care of, leading to submissive and clinging behaviour and fears of separation in a variety of contexts. This pattern provokes subjective suffering and interpersonal malfunctioning (Carcione & Conti, 2007). A more fine-grained analysis shows that many other personality disorders (PD) feature aspects of unhealthy dependency, with borderline, histrionic and avoidant being the most obvious examples and all of them co-occurring frequently with DPD. Moreover, empirical evidence supports the notion that other PDs do co-occur with DPD at high rates (Becker, Grilo, Edell & McGlashan, 2001; Blais, Hilsenroth, Castelbury, Fowler & Baity, 2001), and DPD symptoms are positively related to the majority of DSM-IV PDs from all three clusters (Barber & Morse,1994; Meyer, Pilkonis, Proietti, et al., 2001; Sinha & Watson, 2001; Bornstein, 2005). These data suggest not only that current DPD diagnostic categories lack discriminant validity (Bornstein, 1998) but also confirm Bowlby's intuitions that dependency is a typical human functioning and malfunctioning dimension (Benjamin, 1996; Fernandez-Alvarez, 2000).

A disorder in which only a few thinkers (Kohut, 1971, 1977) have noted the presence of severe aspects of unhealthy dependency is Narcissistic PD (NPD). This is completely lacking in the DSM description of the disorder (2000), which stresses the pervasiveness of grandiosity, need for admiration, lack of empathy, disdain and envy. Kernberg's description contains similar features and pinpoints a grandiose and envious individual, prone to anger and seeking others' attention and admiration (Kernberg, 1974, 1975). NPD sufferers are often seen as self-reliant, independent, unable to form attachment bonds and, at the end of the day, not needing others' help when in distress.

Clinical observations and social psychology research suggest instead that NPD patients tend to fall into fragmented (Kohut, 1971, 1977) dissociated or angry (Dimaggio, Semerari, Falcone, et al., 2002; Dimaggio, Nicolò, Fiore et al., 2008) states when they consider others are not supporting their plans or they feel rejected. Without support from others they tend to become passive or shut-off and thus unable to pursue their life goals (Robins & Beer, 2001). This leads us to think that many aspects of narcissism pathology can be seen to be unhealthy dependency and that, once issues more closely related to grandiose aspects of the self or self-esteem have been dealt with successfully, the main goal of psychotherapy should be to promote autonomy and a stronger sense of personal agency (Dimaggio, in press). This may sound counterintuitive and the resemblance between the prototypical patient with overt dependent features, such as persons with DPD, who are submissive, cling to others and fear abandonment and negative judgement, and prototypical NPD sufferers, who in moments of distress tend to contemptuously shut themselves in a cocoon or an ivory tower (Modell, 1984), leaving the rest of humanity out, may not be at all clear.

In a narcissistic individual's grandiosity and hypervitality Kohut (1971, 1977) sees low self-esteem, a deep sense of being unworthy, neglected and rejected and an incessant longing for feedback that denotes a burning longing for reassurance. Kohut sees a vulnerable individual, in whom the self tends to fragment owing to a lack of empathetic feedback to its affective needs early in development. Clinging to a grandiose self-image is the only choice available when faced with the possibility of the self fragmenting. In Kohut's description, therefore, investing in a grandiose self represents an adaptive reaction to a failure to develop a healthy dependency. In a relationship an individual can experience a state of mutual idealisation and recognition, a sort of ideal cohabitation enhancing the worth, power and omnipotence of both self and other (Kohut, 1971; 1977; Ornstein, 1998). Self feels admired by other; this ensures there is a sense of cohesiveness and boosts the idea that self is exceptional. Ryle and Kerr (2002) define this interactive procedure *admired* to *admiring*. When narcissists find themselves in difficult situations, they experience an unpleasant arousal, which automatically drives them to get close to others for protection. In normal individuals an activation of the attachment system surfaces in consciousness in the form of appropriate emotions, e.g. weakness or a need for consolation. With the activation of attachment narcissists instead appear cold, tense and self-reliant and are not consciously aware of any emotions connected with their need for attention (Bowlby, 1988; Jellema, 2000). It is difficult for the "Vulnerable Child" (Young, Klosko & Weishaar, 2003) self-aspect to surface in consciousness. As a result, when looking for support, the self paradoxically appears to be self-reliant. The pattern most likely to emerge is self-reliant self/distant and indifferent other (Dimaggio et al., 2002).

The theories listed above provide a more multi-faceted description of the complexities of an NPD client's psychological functioning than the DSM, which

concentrates entirely on the grandiosity and interpersonal exploitation aspects. In particular, they answer the questions of how a subject, whose only existential motivations are seeking admiration and pursuing grandiose goals, can at the same time feel vulnerable and dependent, and in what particular way these feelings manifest themselves in significant relationships. This is the theoretical path we intend to follow in the rest of this paper, i.e. highlighting maladaptive dependency features in NPD and comparing them with unhealthy dependency in DPD.

Our goal is to achieve a refined NPD pathology and treatment model, in which silently expecting admiration from others (Kohut, 1971) and showing symptoms or interpersonal malfunctioning when such a support is lacking (Dimaggio, Semerari, Carcione, Nicolò & Procacci, 2007; Robins & Beer, 2001) are generally a form of unhealthy dependency and should be given a special emphasis in treatment, even more than challenging the classic grandiose self features (see Dimaggio, Salvatore, Nicolò, Fiore & Procacci, 2010a).

Our analysis will make use of diary and session fragments involving patients with severe manifestations of both NPD and DPD, and will be carried out within the framework of Dialogical Self Theory (DST; Hermans, 1996a), which we describe in the next paragraph.

Dialogical Self Theory and NPD

Dialogical Self Theory (DST) hypothesises that: a) the self is multiple (Angus & McLeod, 2004; Gergen, 1991; Gilbert, 2002; Horowitz, 1987; Markus & Nurius, 1986; Muran, 2001; Stiles, 1999). There is no one thought and action control centre but rather many different autonomous points of view, termed *characters*, *voices*, *positions* or *roles*, some seen as self (me as a loving father, me as a mediocre tennis player, etc) and others belonging to the self's external domain (my lovely fiancée, my strict boss). Many authors advocate the existence of a multiple self, where the different voices, each with its own set of wishes, needs and action tendencies, surface in line with the demands of interpersonal situations and the problems to be confronted (Dimaggio & Stiles, 2007; Gergen, 1991; Hermans, 1996b; Markus & Nurius, 1986; Neimeyer, 2000). The various characters can temporarily take control of the action and speak from the "self position" (Dimaggio, Salvatore & Catania, 2004; Hermans, 1996a, 1996b; 1997; Hermans & Dimaggio, 2004); b) these inner characters interact among themselves through a - both verbal and non-verbal - dialogical interaction. The meaning of events emerges from the form the dialogue takes. The characters can agree or disagree. One can dominate over the others and some voices can be constantly submerged or only emerge rarely (Bakthin, 1927/1973; Santos, Gonçalves, Matos & Salvatore, 2009, 2009; Dimaggio, Salvatore, Azzara et al.; Hermans, 1996a,b; Hermans & Dimaggio, 2004; Ryle & Kerr, 2002). For example, the dominant character in narratives is the strong self and the weak

side, seeking attention, can have difficulty emerging, thus making it impossible for a subject to ask for help or obtain it.

Psychological health and social adaptation can depend on (a) the existence of a sufficient variety of voices, i.e. a minimum degree of self-multiplicity — persons need many voices in order to deal with the host of problems arising in a demanding and ever-changing society; (b) the ability to be aware of one's many self aspects; (c) the ability of the different voices to engage in a dialogue involving mutual recognition, negotiation of conflicts and openness to innovation— the voices need to be reciprocally aware of each other's perspectives and able to engage in a dialogue respecting their differences; (d) the creation of superordinate points of view, called meta-positions (Hermans, 2001) or metacognitive integration (Semerari, Carcione, Dimaggio, et al., 2003), which provide a sense of coherence, coordinate the different self-aspects and make it possible to solve conflicts and find new and more effective solutions (see Dimaggio, Hermans & Lysaker, 2010b for associations between problems in self-multiplicity and psychopathology).

From this theoretical perspective we will demonstrate how patients with NPD adopt unhealthily dependent mental states and behaviours that are, in part, similar to those of some dependent personality disordered patients (e.g. pressing seeking of the other, strong desire for approval and support, relationship-facilitating self-presentation strategies to strengthen ties to a significant other, action paralysis when support is lacking). We shall, of course, also show the other side of the coin, i.e. highlight the many differences in how unhealthy dependency is processed in the two disorders.

One key difference is in the desired and feared dialogical interaction patterns underlying the two disorders. While in DPD the desired pattern can be schematised as *vital self v. close, loving and attentive other* and the feared pattern as *abandoned and devitalised self v. distant, inattentive and unavailable other*, in NPD the desired pattern can be schematised as *effective and admired self v. admiring other*, while the feared one is *self seeking admiration v. other denying attention and support*, causing the self to fall into *a state with poor-self-efficacy, lack of agency* (Dimaggio, in press), *action paralysis and sense of emptiness*. Moreover, when NPD sufferers face real-life setbacks, in particular abandonment by a romantic partner, they enter states in which they seek attention from another. However the latter is however perceived as ineffective and they react by assuming a defeatist stance. DPD sufferers, instead, cling desperately to their caregivers in the expectation of receiving help.

We shall now present some material from two patients' psychotherapies - Paul, suffering from NPD, and Sandra, suffering from DPD - to highlight the similarities and differences between the two disorders.

Unhealthy dependency in NPD. Paul's case

Paul is a 36-year-old patient meeting NPD criteria. He has a postgraduate doctor's degree and intends to pursue a university career. He seeks therapy because of frequent panic attacks and a chronic sense of depressive emptiness. In the early stages of his therapy his narratives – featuring a typical narcissistic narrative style, i.e. detached and intellectualising (Dimaggio et al., 2007; 2010a) – are entirely about his romantic involvement with an ex-student (he taught Italian for a short period in a language school for foreign students), which she has recently broken off. The dynamics of the relationship are of special note: Paul searches for the other and projects a disinterested, friendly self-image of himself; when she accepts his proposal and engages in the relationship on this basis, he looks for more proximity and intimacy and becomes angry and demanding when she does not satisfy his romantic requests; at this point she disengages from the relationship and he starts to search for her in a highly aroused state, in the end offering again his disinterested help like a friend. The cycle restarts.

In this description Paul displays some of the behaviour typical of unhealthy dependency (Bornstein, 2005), like strong desire for support, relationship-facilitating self-presentation strategies to strengthen ties with significant others, and an urgent and often angry and vindictive seeking of the other when there is the threat of being abandoned. During the first few sessions Paul provides a perspicacious description of his feelings of unhealthy dependency:

Session no. 4

"Maybe every time I've got interested in a girl I've tried to adapt myself to that person without really being myself […] I believe it depends entirely on a question of self-esteem because you always try to be acknowledged by the other and so in a way you try to understand what the other wants and to adapt yourself to that desire […]"

We maintain that this description contains the essence of pathological dependency in narcissists: the other's importance is regulated by the pressing need for the other to acknowledge one's personal worth. In DST terms the desired *self-position* is *effective, admired self v. admiring other*. This dialogical pattern takes on various nuances in line with swings in self-esteem, regulated in their turn by outside events. If their self-esteem is based on negative values, NP disordered patients fall into a depressive state (Dimaggio & Stiles, 2007; Dimaggio et al., 2007), in which they are seized by a pervasive awareness that their grandiose image has collapsed. In this instance the presence of an *admiring* other has the function of removing the feared representation of an ineffective and failed Self. In this mental state patients are likely to pressingly seek the other and – like Paul – become angry and vindictive if the latter backs off, thus confirming their negative self-perception. In this case they are in the feared *self-position*, i.e. *ineffective and failed self v. other confirming failure by not providing attention*.

The next passage, instead, shows how the *effective and admired self v. admiring other* pattern evolves when life events cause a positive swing in Paul's self-esteem, signalling in turn a shift from his depressive mental state to a grandiose one based on personal effectiveness (Dimaggio et al., 2002; 2007):

Session no. 5

Pt.: […] on Thursday the university professor […] told me there are some funds…are you interested? Of course!. […] I feel at home at university. I reckon school-teaching is just for failures.

T: Um! What did you feel when the professor mentioned this possibility?

Pt.: Uh, I don't know…but anyway the first thing I did was to call Claire.

T.: And what did you feel, what were you thinking while you talked to her about these prospects?

Pt.: I was happy […] I don't know if I got to this not least by considering the fact that Claire has been a fundamental factor behind my self-acknowledgement.

T.: Um!

Pt.: Because from the moment at which I feel recognised for what I want to do, I mean university, perhaps Claire becomes less important. I sort of manage to become more independent.

T.: But do you, Paul, really have a sense of greater detachment from Claire at this moment?

Pt.: I, yes, but simply because I've got tired. […]. I mean that before I didn't ask myself who this person is but now I am again. And it's the same state of mind I was in one year ago when we hardly knew each other.

T.: When you were in, let's say, a reference position, I mean you were her teacher…

Pt.: I was still doing my doctorate, and wasn't in the thick of my crisis…(pauses) Yes, I've thought about this, I mean that I bet this position of strength due to the news from the university has brought me back to that same…

T.: And in fact this was what I wanted to grasp…

Pt.: No, it's a horrible thought, I didn't like it. However, it's as if, as long as I was teaching at the school, I'd look for Claire….

T.: Um!

Pt.: …And, at the moment at which I become a university teacher, the question "Why should I look for Claire!?" arises. It's a horrible thing (laughs). It's strange that this happens to me because it's absolutely not a class question…

T.: Let's say, if I've understood correctly, Claire becomes less important for you at the moment at which you feel closer to a position of strength and prestige. We also have to include here that you had a strong impulse to let Claire know you were reaching this position of prestige. Then, immediately afterwards, you felt your movements in the relationship could be freer, to the extent that you were also expressing more critical thoughts about it […], about Claire's negative characteristics. So maybe […] one could think that among the fundamental impulses behind your relationship with Claire is that of being acknowledged, having the feeling that the other can see your worth…

Pt.: (long pause) Yes, there could be… (pause) and does my father have something to do with this? Because on one occasion I noticed… that when I don't feel acknowledged I become like a child [..].

After the transition to the grandiose mental state the patient actively seeks the other's admiration, although now the aim is not to ward off an awareness of a collapse in the grandiose image but rather to satisfy the need to expand it through the admiration received from the other ("the first thing I did was to call Claire […]"; "I don't know if I got to this not least by considering the fact that Claire has been a fundamental factor behind my self-acknowledgement"). Incidentally, in the grandiose state a patient loses interest in the other (especially if the latter does not explicitly provide the admiration expected). Occupying the patient's internal stage is a contemptuous *self-position*, for which the other is "interchangeable" as regards the external and situational factors capable of confirming the grandiose image ("Who is this person?"[…]; "Because from the moment at which I feel recognised for what I want to do, I mean university, perhaps Claire becomes less important because. I sort of manage to become more independent."; "it's as if, as long as I was teaching at the school, I'd look for Claire […] And, at the moment at which I become a university teacher, the question "Why should I look for Claire!?" arises.).

Unhealthy dependency in DPD. Sandra's case

Sandra is a 35 year old DPD patient. She has a degree and does a clerical job in a firm. She seeks therapy because she has continuous panic attacks and often falls into depressive states, linked to a sense of personal inadequacy and unworthiness. During the earliest sessions it emerges that her symptoms come when she feels that her boyfriend might leave her and she has a growing sense of distress. In these circumstances she seeks her boyfriend and hides her suffering behind a tendency to comply with the other's every need in order to get the relationship going again. When her distress at seeing that she is about to be abandoned becomes unmanageable, she angrily asks the other for continuous reassurance, as she judges herself to be unworthy

and guilty of the potential worsening in their relationship. Analysing Sandra's diary extracts in line with the DST, a variety of *self-positions* can be seen occupying her inner stage and shaping her narratives, while she herself is not aware of them or of how they surface in response to variations in interpersonal contexts. It is possible to schematically define two patterns: one the feared dialogical relationship and the other the desired one. An example of the first can be seen in the following diary excerpt:

"I need his night call. If it doesn't arrive, I go into a dark mood. I feel I'm in a narrow cave, with a low ceiling and dim light. You can't see the exit at the end of the tunnel; everything's dark down there. I lose my breath and my body and stomach shrink. No desire. I feel sad, alone and not loved. No warm, no well-being, no inner calm. It's all about "he doesn't care two pence about me."

Sandra experiences a sense of devitalised and terrifying emptiness and a total lack of desire when she sees her boyfriend is not emotionally and physically present or does not display warmth and attention towards her. The dialogical pattern surfacing can be termed *empty-devitalised self v. distant, inattentive and unavailable other*.

The *empty-devitalised* position can switch to an *angry self-position*, in which she feels herself justified in betraying the other in retaliation for being abandoned, as becomes clear in the next extract:

"…And thinking about him? A mixture of anger and sadness: it's your fault if I'm here; it's you that shoves me into other people's arms; it's you, with your indifference, that squashes other people's needs like a bulldozer, and you aren't even aware of other people's state of mind. […] The only thing to pull me out of this torpor is betraying him. It makes me feel free, brave and capable of stepping back, concentrating on myself, thinking about myself again. Not subordinating my life to him."

Note that the concept of self-position we use here is largely consistent with concepts such as self-representation in relational psychoanalysis (see Bromberg, 2004, for a view of relational psychoanalysis consistent with dialogical self theory). In this context, the Core Conflictual Relationship Theme (CCRT; Luborsky & Crits-Christoph, 1990), a tool devised to tap the number of interpersonal relationship patterns in a patient's narratives contains the patient's *Wish*, a *Self-Representation*, a *Representation of Others' Responses* to the core wish and a *Representation of the self's response to others' responses*. Thus, with the patient wishing, in the *empty-devitalised self-position*, to be loved and cared for, and with the *Representation of the Other's response* being rejection, the angry *self-position* surfacing in this second extract probably represents the patient's automatic response to the representation of the other's negative response. This self-position then triggers a new pattern based on a wish for attention, with the Self-Position being *deserving care v. another guilty of not providing it and deserving to be punished*. In this transition the self enters a position involving a wish for autonomy and exploration. This is a temporary but relatively sthenic emotional position and the only

one in which the other is represented as being not indispensable for the Self ("Betraying him makes me feel free, brave and capable of stepping back, concentrating on myself and thinking about myself again. Not subordinating my life to him."). The fear of being abandoned is temporarily avoided, but only through a recourse again to the attention of others, who become substitute male figures.

The shift that occurs when the significant other is or is seen to be present is striking:

"I've never been on heroin, but I can imagine the pleasure your body feels when injecting the substance after the craving. It's like a maggot that has been under the sun for too long and is about to dry up and then all of a sudden it finds wet earth. It finds harmony again, a balance with nature, a vital interdependence with its surroundings. And energy to live, act and smile. The phone call I've waited for so long arrives and it's like heroin to me."

This *self-position* can be schematised as *vital self v. close, loving and attentive other*. In this case the representation of the other's response is positive. Sandra experiences a state of inner vitality, featuring – as is typical in DDP - a powerful positive somatic marking (Damasio, 1999; Carcione & Conti, 2007).

Specificity of unhealthy dependency in NPD compared to DPD

In this paragraph we shall outline the differences between unhealthy dependency in NPD and in DPD. In line with the DST, we hypothesise that experience in both disorders is driven by a cast of inner characters weaving a limited and impoverished dialogical interaction, which prevents them from moving freely in the varied and changing contexts that life presents (Dimaggio, Salvatore, Catania, 2004). This impoverishment also embraces the way in which the feelings of dependency on significant figures get expressed and in both cases the view that the other is absent or is neglecting one triggers a limited and stereotypical response repertoire. We have said that the desired pattern in DPD can be schematised as *vital self v. close, loving and attentive other* and the feared one as *devitalised self v. distant, inattentive and unavailable other*. In NPD, instead, the desired pattern can be schematised as *effective self, admiring other who in turn admire the self*, and the feared one *ineffective and failed self v. other critical or not providing attention*. These patterns also regulate shifts between typical mental states during interactions with significant figures. When a relationship confirms the desired pattern, both patients experience a joyful state, but central to narcissistic joy is a feeling of high self-esteem, while in dependent patients joy is experienced as a vital somatic state, in which it is seeing that one is present in the other's mind that is central.

Moreover, a narcissist's joy is essentially solipsistic and only apparently linked to the state of a relationship. When the patient we depict gets a glimpse of personal

success, he first seeks the other as a spectator and "amplifier" of his grandiose image and then, once this task has been acquitted, looks at him/her with contempt. In the dependent patient, on the other hand, maintaining the other's presence and attention remains fundamental for maintaining the joyful mental state.

Without the other, NPD patients experience a depressed, empty state similar to what clinical experience has shown in dependent patients (Carcione & Conti, 2007). The state is linked in NPD to a lack of events capable of feeding the grandiose self-image; for example, after the joy for an earlier success has deflated and self-esteem is again open to discussion (Dimaggio et al., 2002). In this state the lack of preferential attention from the other can confirm an image of self as a failure and precipitate an out-and-out depressive state. In such states patients become dysphoric defeatists and, albeit continuing with their therapy, take a contemptuous attitude and deny their therapist can help them in any way.

The patient we depict tried to avoid this shift by activating a pressing searching for the other with the sole aim of winning her exclusive and admiring attention, with which he was able to partially recover his positive self-image. In dependent patients the empty state is completely different. Once again the self-esteem dimension is not central, getting activated, in fact, when the significant other is absent - even in non-conflictual periods in the relationship – and patients are unable to feel vitality or take action on the impulse of personal desires.

In both disorders unhealthy dependency can manifest itself with periods of vindictive rage towards the significant other. In narcissists the rage is a transition state (Dimaggio et al., 2002), which gets activated when they see others as rejecting or hindering their goals, and serves to avoid the shift towards the empty depressive state, in which, instead of blaming others, narcissists collapse under their own perception of limited personal worth. In angry periods a lack of response by the other to the need for admiration or special attention, especially when a hoped-for success takes it time coming, makes it possible to repress the threat of the depressive state by ascribing the reasons for one's suffering to the outside, i.e. to the behaviour of another individual. The other's withdrawal is then experienced by the subject as an out-and-out injustice, a denial of recognition to one's special worth, which is not much different from a lack of recognition of one's higher worth by the world.

In dependent patients too anger is a response to the other's negative response, or to a perception of the latter's disinterestedness and similarly seems to represent a sthenic transition state, in which the strength that the anger gives to their claims "protects" patients from entering the empty state. However, in dependent patients, once again, the anger does not perform the function of preserving self-esteem but only that of giving the subject that experiences it an apparent sense of independence from the other, thus reducing temporarily the intensity of the need to be close to the significant figure.

Table 1. Dialogical interaction patterns and dependency phenomena in DPD and NPD

Type of disorder	Dependent Disorder	Narcissistic Disorder
Desired dialogical interaction pattern	Vital self v. close, loving and attentive other	Effective and admired self v. admiring other
Feared dialogical interaction pattern	Devitalised self v. distant, inattentive and unavailable other	Self seeking admiration v. other denying attention and support
Nature of vital state	The self-esteem dimension is absent or marginal	The self-esteem dimension is central.
	In this state the other remains relevant to keep the joyful state	In this state the other can lose importance and become the subject of contempt
Nature of empty state	Somatically marked terrified-depressed-devitalised, connected to absence of other	Depressed-anaesthetised, connected to absence of events feeding the grandiose self
	Absence of active goals	Absence of active goals
Nature of angry state	Vindictive anger v. other not responding to requests for affection with proximity	Anger due to injustice suffered v. other not responding to need for admiration with an exclusive acknowledgement of one's personal worth
Shifts in mental states	Based on signals of other providing attention	Based on situations influencing self-esteem

In the patient depicted by us the anger leads to a searching for a substitute outside source of attention. In our narcissistic patient the path taken by the anger seems decoupled from relationship events and can go in two directions: towards either the empty depressive state if the subject consciously perceives his failure and this causes a collapse in his grandiose self-image, or the joyful state, if an outside event reinforces his self-esteem and restores the self-image.

Implications for psychotherapy

The majority of PD patients do not fit into the DSM diagnostic categories, as they often present features from a wide array of different disorders. A useful strategy, therefore, for understanding patients' pathologies with a view to treatment planning is to focus on the set of basic dispositions (e.g. unstable self-esteem or perfectionism) underlying many PDs, albeit with unique interactions with other personality features in each specific patient (Dimaggio & Norcross, 2008).

In this work we have focused on the unhealthy dependency trait in NPD. This trait is not contemplated by the nosography, while recent literature on this PD analyses it much less than grandiosity. We have performed a phenomenological analysis of unhealthy dependency in NPD in the light of the DST and through a comparison with unhealthy dependency in DPD. NPD Patients invest in their relationships with others to defend their grandiose self-image when this is threatened or to preserve and expand it when not threatened. In other words, narcissistic patients do not depend on others like dependent ones do, but need other's approval and admiration, most of all when there is a risk of approval and admiration by the world disappearing.

In working on such complex dependency dynamics in narcissistic patients, psychotherapists should pay attention to the range of different reactions they experience toward patients' different self-positions. A narcissistic patient may feel fine when a patient's need for admiration manifests itself in a request for help, addressed to the therapist, like "the only one able to understand" his story", but experience difficulty when, some sessions later, the same patient becomes cold and arrogant. Such a change in the patient can evoke a shift in therapists from an I-position loaded with self-efficacy to one featuring low self-esteem and hurt at being criticised. It is important clinically as well as theoretically to note that the responsibility for such inner shifts in the therapist is not totally the patient's. Interpersonal psychoanalysis (Aron, 1996), to give just one example, emphasises that therapists bring their personal history, attitudes, beliefs, and values to therapy relationships and that these contribute to both the positive and problematical aspects of forming therapeutic relationships. We find Bromberg's motto (2004) "*Who is talking with whom*?" valuable in guiding therapeutic actions. During the flow of conversation, clinicians can ask themselves which part of the patient is speaking with which part of the therapist. Is it a child asking for attention from an adult, who, however, frightens it? Is he/she trying to seduce a person, who, in turn, has need of gratification? According to the DST the therapeutic relationship is thus a complex dance in which different partners meet, dance together for a while, and move on. Some partnerships work well, while others are problematic, with partners unwilling to cooperate.

When faced with a narcissist's dependency on admiration, a therapist should know how to "dance together" as the patient shifts from dependency to grandiosity. In the first place, as already theorised by Kohut (1971), a patient should be allowed the possibility of being admired by the therapist. The former is thus able to experience *in vivo*, in the therapeutic relationship, a dependency on the therapist's admiration, the repercussion of which is generally – especially in the early stages of a therapy – an idealisation of the therapist him/herself. In line with Kohut (1971), we suggest that a therapist should partially accept this idealisation, because it promotes the therapeutic alliance and constitutes the only way in which a patient is initially able to establish an attachment relationship. In the second place, patients exhibit grandiose aspects in order

to be accepted and win approval. Therapists should not challenge these grandiose aspects, as patients can feel invalidated and hurt, or a fragile self can surface and feel threatened (Dimaggio et al., 2007). In both situations patients may react angrily for self-defensive purposes, or become depressed, and will probably drop out of therapy. Therapists should therefore constantly monitor their tendency to challenge the grandiose self and, each time they feel hurt and driven to counter-attack, should silently back off. They need to achieve an empathic stance and make contact with the aspects of patients that ensure them at least a slight sense of wholeness. It is also important, when a patient enters states of contemptuous rage, for therapists to pay strict attention to the way in which they themselves may have contributed to such a reaction and to discuss it openly together, without blaming the patient for what is largely a self-protective reaction against feelings of failure, inner emptiness and fragmentation.

On the basis of these presuppositions regarding the therapeutic relationship, the goal for treating dependency in NPD should be to stimulate the transition from an unhealthy dependency to a healthy one. This means that patients can be validated as regards their need for admiration, which all human beings have, but should be encouraged to try new self-aspects – in particular, a self-position *capable, during fragile states, of seeking attention in a functional manner* – and new dialogical interaction patterns – especially *self seeking attention v. other ready to provide it*. Clinicians can help patients access the parts of the self that may be suppressed or warded off. The very kernel of therapy with narcissistic patients is to let them access the feelings of agency and of the right to pursue their own goals that derive from their innermost desires, thus making them more independent even when confronted by setbacks in everyday life.

We shall now return to accessing the dependent self. This needs to be avoided in the earlier therapy stages because a premature sense of being fragile or needing support can elicit negative reactions in patients who still need to resort to the grandiose self. A patient may seem consumed with despair because life is too hard and she has too many problems. But a clinician might simultaneously detect an angry tone in her speech. A sensitive exploration of this anger may lead to the discovery of a part of the self that is seeking care but is constantly suppressed because the patient feels others will refuse her requests for help. The aim of such a therapy might thus become to help the patient to give full voice to the care-seeking part by, for example, exploring the idea that no one will provide attention and developing mature strategies to obtain it. In situations like this it is important for therapists to attend to non-verbal signals: posture, tone of voice and facial expressions. The suppressed parts may be more likely to appear in a patient's non-verbal behaviour and gestures. When a clinician notices non-verbal behaviour contrasting with a patient's prevailing discourse, it may be valuable to give voice to this facet, by saying, for example: "While you were speaking about your son, I noticed a flash of joy in your eyes, which you did not have previously. I haven't seen you so full of life for some time, and perhaps even you are unaware of this potential." Another way

of accessing suppressed self-parts is through role-playing or two-chair work (Greenberg, 2002), where patients play roles they are not used to, dedicating time and concentration to emotional experiences they usually ignore. Such techniques can stimulate an increased awareness of feelings previously in the background. Successful therapies always involve an enrichment of the patient's inner world, with the entry on stage of characters capable of asking for and providing help, and cooperating, and of characters looking critically at the tendency to compete.

Finally, many forms of psychotherapy consider promoting patients' self-reflection as a therapy goal. This involves building up a part of the self that then becomes the observer of the other parts acting in a scene. In other words, self-observation is achieved by promoting multiplicity and differentiation in the self. Once patients have developed this new observer position, they can adopt it as a perspective from which to observe their own cast of characters and their often problematic attitudes.

Our study has several relevant questions that we hope to answer in our future clinical and theoretical work. For example the model of Dialogical Self Theory is presented in its more general formulation and it's only partly specifically connected to the phenomenology of narcissism and, furthermore, it is not completely linked to the interactionist model of Bornstein that is used as theoretical model of reference in order to describe the different aspects of dependency. Another question is if utilyzing different theoretical framework would leave unchanged the diagnostic labelling from which our theoretical speculation has started. Another more question that deserves to be further clarified is the concept of "Wish", that should be more sistematically explored in its relation to the concept of self-position and to the dynamic interchange of self-positions. Finally, our work present the intrinsic limitations of a single-case qualitative study, like lack of generalisation.

Though these limitations, we hope we have provided a sensitive and nuanced description of the dependent self in narcissistic patients, showing how these features are a problem that many other PD patients experience but with different phenomena, and providing therefore a promising guide for the honing of treatments to such difficult but treatable patients.

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