Understanding and Treating Narcissism With EMDR Therapy

Dolores Mosquera
INTRA-TP, Instituto para el estudio del Trauma y los Trastornos de la Personalidad, A Coruña, Spain

Jim Knipe
Longmont, Colorado

Narcissistic personality disorder and narcissistic trait disorder are associated with selfish behaviors and lack of empathy toward others. Clients with either of these initial presentations in therapy show a self-centered profile and lack of empathy or concern about the suffering they may cause in other people, but this is only part of the picture. Sometimes the lack of empathy and selfishness is only a defense. To fully understand this problem, it is also necessary to be aware of underlying self-definition issues that drive the behavioral manifestations of narcissism. As in any psychological problem, eye movement desensitization and reprocessing treatment needs an understanding of how early experiences lead to future symptoms. Understanding the pathways from early experiences to narcissistic features (including covert presentations) is essential for an adequate case conceptualization as well as comprehending the defensive mental structures that impede accessing the core adverse experiences underlying the symptoms.

Keywords: narcissism; eye movement desensitization and reprocessing (EMDR); narcissistic personality disorder; trauma; adaptive information processing

The overt qualities of narcissism such as grandiosity, exploitativeness, arrogance, interpersonal problems, and rage are familiar for clinicians, but covert presentations can go unnoticed and therefore untreated. The goal of this paper is to focus on diverse forms of presentations of narcissism, how it can be conceptualized from the adaptive information processing (AIP) model and treated with eye movement desensitization and reprocessing (EMDR) therapy (Shapiro, 2001).

The Concept of Narcissism

Narcissistic individuals can be defined as people who are excessively preoccupied with issues of personal adequacy, power, prestige, and vanity (Millon, 1996). We can define narcissism from three different perspectives: the behaviors of a narcissistic individual, the "object relations" patterns of narcissism (i.e., the ways that a narcissistic person thinks of relationships with others), and the phenomenological aspect of narcissism (i.e., how it feels to be a narcissist). Different behavioral aspects of narcissistic personality structure have been defined in terms of "the dark triad"—trait clusters that are related and often coexist but are conceptually separate: (a) *narcissism* (entitlement, assumptions of superiority to others, dominance behaviors), (b) *Machiavellianism* (glib social charm, manipulativeness), and (c) *psychopathy* (callous social attitudes, impulsivity, interpersonal antagonism; Jonason, Lyons, & Bethell, 2014; Kowalski, 2001).

For (EMDR) therapists treating people with narcissistic features within an AIP model (Shapiro, 2001), the phenomenological aspect is particularly important because an AIP approach specifically targets clients' unwanted feelings and unhappy subjective experiences. Phenomenologically, narcissistic people can be described as overly focused on and protective of a highly valued image of self. This image is often idealized, in the sense that the person's self-concept is distorted, with excessive self-valuation, attitudes of specialness, superiority, entitlement, and immunity to some of the common rules of appropriate behavior.

As EMDR therapists, it is important for us to note that this type of distorted, overly positive self-image, based on a large degree on prior life experience, is susceptible to targeting and resolution through

EMDR-related interventions. Just as the procedures of EMDR therapy can be effectively used to target and resolve unpleasant emotion and overly negative self-definition, similarly, the core memories engendering an overly positive sense of self can also be targeted (Knipe, 2014) to bring those memories to adaptive resolution, resulting in a more realistic self-appraisal.

For many individuals, narcissistic behaviors appear to be the façade of a more complex picture. Various theories (Gabbard, 1989; O. Kernberg, 1975; Millon, 1990) posit that the person needs to act as if he or she was superior or better than others to compensate the inner, hidden self-definition of being a failure or mediocre.

Along with these personal characteristics in the clinical picture, there is often a lack of empathy for the feelings and desires of others (American Psychiatric Association [APA], 2013), which has been theorized to stem from a deficiency in "object perception"—fully perceiving the reality that others have separate needs, perceptions, attitudes, and so forth (Masterson, 1981). Often, narcissists do not really relate to others as separate, different human beings but simply as "objects" to be used to further a personal need (Millon, 1996). We speculate that this impairment in empathy is a piece of the damage caused by early frustration of inborn attachment "action systems" (van der Hart, Nijenhuis, & Steel, 2006) and view it as frustration regarding early attempts to connect empathetically with others, during very early childhood, or a simple imitation of what they learned from their caregivers (Mosquera, 2012, 2013).

Finally, the experience of a narcissist may have moments of euphoric pleasure when a "victory" is achieved, which is thought to prove his or her superiority. However, we have noticed in our clinical practices that this type of goal attainment, even when successful, does not tend to go deep. It is less satisfying to be admired as "the victor" than to be truly loved. In the treatment of a client with narcissistic features, these three viewpoints all need to be taken into account, as will be described in the following text.

The Development of Narcissism

Clinical studies have indicated that the childhood experiences of physical abuse, sexual abuse, emotional abuse, physical neglect, and emotional neglect are common among patients with personality disorders (Battle et al., 2004; Bierer et al., 2003; D. M. Johnson, Shehan, & Chard, 2004; Luntz & Widom, 1994; Rettew et al., 2003; Yen et al., 2002; Zanarini et al.,

2000; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989; Zanarini et al., 1997; Zanarini et al., 2002). Studies involving convenience (Gibb, Wheeler, Alloy, & Abramson, 2001; Grover et al., 2007; Tyrka, Wyche, Kelly, Price, & Carpenter, 2009) and small community samples (J. G. Johnson, Cohen, Brown, Smailes, & Bernstein, 1999; J. G. Johnson, Cohen, Chen, Kasen, & Brook, 2006; J. G. Johnson, Smailes, Cohen, Brown, & Bernstein, 2000) have also supported this association, but it remains unclear whether the relationship between personality disorders and childhood adversity exists in representative general population samples (Afifi et al., 2011). This research cited investigated the development of narcissistic personality disorder, but the assumption of the authors is that the conclusions of this research also pertain, perhaps to a lesser extent, to other individuals who are not diagnosable with narcissistic personality disorder but have a narcissistic trait disorder.

Cohen et al. (2014) report that childhood maltreatment, including emotional, physical, and sexual abuse and neglect, represents a potent environmental risk factor for personality pathology. These authors point out that a significant amount of research links childhood maltreatment to adverse outcomes in adulthood, including personality pathology (Collishaw et al., 2007; Lobbestael, Arntz, & Berstein, 2010). However, it remains unclear whether specific types of childhood maltreatment predict specific types of personality pathology.

Meta-analytical and empirical studies suggest that self-centered, narcissistic personality traits have been rising across the globe over the past few decades (Cai, Kwan, & Sedikides, 2012; Twenge, Konrath, Foster, Campbell, & Bushman, 2008; although see also Trzesniewski, Donnellan, & Robins, 2008). The "narcissism epidemic" is observable in increase in the scores on the Narcissistic Personality Inventory (Twenge et al., 2008), in the content of pop song lyrics (DeWall, Pond, Campbell, & Twenge, 2011), self-centered use of words and phrases in books (Twenge, Campbell, & Gentile, 2012), and in decrease in dispositional empathy (Konrath, O'Brien, & Hsing, 2011). Narcissism has been linked to characteristics of a culture (Foster, Campbell, & Twenge, 2003), and the change in narcissistic dispositions could have a direct relationship with cultural change (Cai et al., 2012), which is often fueled by economic development (Hamamura, 2012). Despite a mushrooming of research into generational and cultural differences in narcissism, the proximate causes of these differences are still unclear (Lyons, Morgan, Thomas, & Al Hashmi, 2013).

Narcissism and the EMDR/Adaptive Information Processing and the Psychoanalytic Models of Psychotherapy

An EMDR approach to the treatment of narcissism begins with the assumption—a hypothesis—that narcissism is based on difficult and damaging early life experiences either specific discrete traumatic events (Afifi et al., 2011) or the more common situation of "traumas of omission"—the situation of a child repeatedly being frustrated regarding needs for attachment and nurturing (Cohen et al., 2014). We are assuming that, for the adult individual with narcissism, trauma of both kinds has had an influence, not only in creating dysfunctionally stored memories of disturbing events but also other trauma-based dysfunctionally stored elements (DSEs; Gonzalez & Mosquera, 2012) such as psychological defenses and often dissociation (i.e., lack of full conscious access between separately functioning self-states/memory networks).

The theoretical base of our work is an integration of EMDR's AIP (Shapiro, 2001) model and a psychoanalytic perspective (O. Kernberg, 1975; Kohut, 1971; Masterson, 1981; Millon, 1996). These models differ in the following ways: Psychoanalytic theory has subconscious, projections, and defenses. Defenses are understood to serve a protective function and are learned in early childhood as a way to compensate failures or lack of attunement. The AIP therapy model, in contrast, sees the basis of psychopathology in dysfunctional memory networks, and posits that some networks are held out of awareness because the activation of those networks is potentially overwhelming and threatening. These therapy models share the assumption that early childhood experiences can be related to specific features of adult psychopathology.

Both theories view narcissistic features as final outcomes of a neglecting environment, chronic abuse, or other adverse experiences (Afifi et al., 2011), but these features can also be related to excessive nonrealistic appraisal and over-pampering (Jonason et al., 2014; Kowalski, 2001; Millon, 1990; Stone, 1993). A variety of attachment disturbances with primary caregivers has also been found to lead to lack of empathy and self-centeredness (Bennett, 2006; Campbell & Foster, 2002; Cramer, 2010; P. F. Kernberg, 1998; Lyons et al., 2013). Because narcissism often functions as a psychological defense (P. F. Kernberg, 1998; Knipe, 1998; Mosquera, 2008)—that is, as a way of preventing awareness or emergence of emotional disturbance— there can be a variety of difficult life circumstances that lead to the development of this defense.

In this article, we are proposing the hypothesis that with appropriate preparation and appropriate compassionate attunement from the therapist, both the dysfunctional memories and the other DSEs can be brought to adaptive resolution through particular AIP interventions, involving focused sets of bilateral stimulation. This article provides a general guideline and is not meant to minimize the enormous complexity and variety of narcissistic personality structures that may underlie the surface behavioral presentation.

Narcissism and Early Trauma

Therapists are often primarily aware of narcissism as a cause of hurt or damage, perpetrated by narcissistic individuals, in clients who are coming to therapy. For clients who have been hurt in this way, there needs to be a focus on how maltreatment has caused feelings and a self-definition of helpless victimization. But when the client is an individual who has narcissistic traits, a different perspective is needed, one that takes into account that individual's experience of self and others and also an awareness on the part of the therapist of how a narcissistic style can stand in the way of that person having normal enjoyment of satisfying life experiences, achievement of therapy goals, and healthy relationships with others.

We could think of narcissism as an emotional problem that is often well hidden from the view of others and evident only in its damaging effects on the person or people in relationship with the narcissistic individual. People who are narcissistic put much energy into not just adapting but looking exemplary—better than others. Most people would be distressed to some degree if they appeared awkward or flawed in the eyes of other people, but for the narcissistic person, this distress is probably amplified because it is a loss of an important defense against unresolved disturbing feelings. For example, if the narcissistic individual learned as a child that "I must appear intelligent and impressive to other people at all times to earn my parents' love," then even a minor lapse in appearing intelligent may bring up all the feelings of emotional abandonment that occurred in the original dysfunctional relationship with the parents. Thus, the individual is constrained to look impressive at all times to maintain this defense and avoid a reactivation of these early childhood feelings of abandonment and unlovableness (P. F. Kernberg, 1998). For these reasons, treatment of narcissism with EMDR is likely to ultimately involve targeting early traumas of omission, where the parents' indifference to the child may influence the child to become an almost perfectly

exact replica of what the parent needs. In this way, the child's need for connection may become partially satisfied (Cramer, 2010; Winnicott, 1965).

This is not to say that narcissism is entirely caused by difficult early experience. Narcissism is a personality trait partially related to genetic factors (Livesley, Jang, Jackson, & Vernon, 1993). Nevertheless, a core hypothesis of the AIP approach presented here and also elsewhere (Stone, 1993) is that early adverse life experiences and attachment disturbances contribute substantially to the problem of narcissism in the adult, especially regarding lack of empathy and self-centeredness.

Pathological Self-Centeredness Versus Normal Narcissism in Childhood

Children with narcissistic pathology exhibit a kind of self-centeredness that is different from the normal narcissism of childhood (P. F. Kernberg, Weiner, & Bardenstein, 2000). In normal narcissism, children's need for dependence and admiration is fulfilled by the age-appropriate attention received; they are able to acknowledge nurturing with reciprocity and gratitude (P. F. Kernberg et al., 2000) and to easily learn the satisfactions of empathy and engagement with others. Normal development can be impaired when there are attachment disturbances (Bennett, 2006) and diverse adverse experiences (Afifi et al., 2011; Lyons et al., 2013), including not being seen by caretakers with eyes that are both realistic and loving (Knipe, 2007; Millon, 1990; Mosquera & Gonzalez, 2011; Stone, 1993). The pathway from early experiences to the development of narcissistic traits can be diverse and may occur differently in different clients. From our perspective, the narcissistic false self is understood to be a defense against traumatic memories, usually traumas of omission and nonengagement, although sometimes overt traumas of commission.

Desperate Search for Positive Regard

A wide variety of traumatic experiences can be beneath the surface narcissistic presentation. It is the observation of the authors that the pattern for this is laid down very early, generally within the child's treatment by different caretakers, or different treatment by the same caretaker, or both. A child may acquire different self-concepts from different caretakers—for example, when a child is idealized by one caretaker and highly criticized by the other. This can happen when mother spoils and father is critical or vice versa, and the parents become polarized in their responses

to the child. This is very confusing for the child, and in these cases, the parents are often using the child as a battleground for their own unresolved conflicts. The pattern of two separate ego states can also get set up when the child does not have, from either parent, sufficient mirroring and recognition of his or her own internal experience and searches desperately for a way to receive positive regard from one or both parents. Seeking to be perfect in the eyes of others is not really fulfilling in terms of connection but may become a "substitute action" (van der Hart et al., 2006), a highly motivated behavior with the goal of having just a bit of a feeling of connection.

Learning the Value of Superiority

The child's parents may have narcissistic features which are hidden from people outside the family but are known and modeled by their children (Mosquera, 2012). The family environment may appear "normal" on the surface, but at a deeper level, there may be insufficient attunement, connection, affection, and recognition of the child's needs (Afifi et al., 2011; Bennett, 2006; Cramer, 2010; P. F. Kernberg, 1998). We have seen clients who grew up in these circumstances and who learned that being special and superior was a way to gain acceptance and thereby strengthen the fragile connection with caretakers. Aspects of the child that were "not special" had to be hidden away, perhaps even excluded from the child's awareness. One client reported that, at age 7 years, he felt very positively connected with his parents when he walked into their cocktail party and went around firmly shaking hands with guests, trying to say clever things to each one of them. When, in treatment, this initially positive memory was targeted, his thoughts quickly went to, "I had to be impressive to everyone, but I couldn't wait to get out of there!" In other words, his positive feeling did not go deep, and it was a thin cover for more basic feelings of inadequacy and lack of connection with his self-centered parents. In his adult life, this client had cultivated "a million friends" but was frustrated by the lack of true intimacy with any of them. It was useful for him to see the origins of this particular way of relating to others, so that he could then proceed toward learning about how to attain more real and satisfying closeness with others.

Even when the child's caregivers are not overtly narcissistic, they may use the child as compensation for their frustrated desires and/or beliefs of being inferior and worthless (P. F. Kernberg, 1998; Millon, 1990; Segrin, Woszidlo, Givertz, & Montgomery, 2013;

Stone, 1993). It is thought that children growing up in an insufficiently nurturing family will gravitate toward meeting parent's needs as a way of maintaining necessary connection with those caretakers. We have observed that when the parent has a narcissistic personality, even in a hidden way, the primary means of connection with parents may be for the child to become the parent's "narcissistic object," a child who appears to be ideal. A parent–child connection is thereby established, but the cost to the child is a disavowal of the particular intrinsic needs and qualities that the parent cannot acknowledge or tolerate. This situation can be exacerbated if the child becomes the focus of excessive and unrealistic praise, pampering, and excessive positive expectations (whether the child is unusually talented or not), which can give rise to what Tartakoff (1966) called the *Nobel Prize complex*. Feelings of superiority and being destined for greatness may be thrilling for the child to contemplate but also may be a source of enormous emotional pressure and be out of synch with that child's actual abilities or behaviors.

Development of Grandiose Self-Importance

Some clients with narcissistic tendencies grow up with a distorted sense of self that reflects distortions in the treatment received from caregivers. In some cases, we have seen "apparently supportive" parents who encouraged attitudes of entitlement. These parents did not encourage attitudes of appropriate humility and self-reflection—that is, learning from mistakes while maintaining a sense of personal worth.

As Stone (1993) states, narcissism may come both from "too much" (overprotection, excessive praise) and "not enough" (severely traumatizing or neglectful environments), and both of these conditions can be occurring in the same family. Stone uses the word *compensatory* to describe this personality structure because the sense of specialness functions to partially compensate for parental indifference and neglect. In this situation, the child may develop an exaggerated desire for "greatness" as a way of shoring up a sense of self-worth in the absence of the ordinary and more reality-based parental praise. In this case, the internal experience and the external behavior of the neglected child may express two very different self-concepts: an outward sense of compensatory specialness covering an inward sense of worthlessness (Stone, 1993). It is thought that narcissistic traits function in this context as defenses preventing the emergence into consciousness of feelings of devaluation of the self (Nathanson, 1992), which can be regarded as a posttraumatic symptom

with origins in the trauma of repeated emotional abandonment. These defenses are frequently complex and elaborated (P. F. Kernberg, 1998).

Development of High Vulnerability to Others' Negative Judgments

Although grandiose self-importance is central to narcissistic personality disorder, vulnerability in self-esteem is an associated feature (P. F. Kernberg, 1998; P. F. Kernberg et al., 2000; Millon, 1990). Given that the narcissistic client's idealized image of self is a distortion of what is really true and he or she is highly invested in maintaining this image, reality perception itself can be very threatening, and other people who freely speak the truth can be seen as threats. Volkan (1973) has described diverse defensive maneuvers (i.e., blaming, devaluing) used by narcissistic individuals to protect the grandiose self from the assault of reality. Thus, narcissistic personality structure can develop as a means of connecting with caretakers, as a way of defending against posttraumatic feelings of abandonment, and as internalization of inadequate narcissistic caretakers.

The child's grandiose sense of self can be understood as resulting from the fusion of the positive aspects of the actual self, the ideal self, and ideal role models, with the elimination of anything incompatible (i.e., partially or completely dissociated), so what is left is a positively exaggerated self-image (P. F. Kernberg et al., 2000). A person with narcissistic traits must disown everything that does not fit his or her grandiose sense of self, which means perceiving others (and the self) in a distorted way. Other people, as well as some parts of the self, are devaluated and separated, leading to lack of integration. This grandiose image of the self is necessary to prevent contact with a painful vulnerability inside. As the child grows up, the price to pay for connection, then, is continuing to be the perfect embodiment of the parent's image of the "perfect child." The child may then generalize from parents to people at large and proceed as if acceptance by other people is contingent on perfection: "I have to be perfect to be minimally okay." An underlying assumption, not always conscious but powerfully present in the persons beliefs about relationships, is as follows: "If people do not agree with my very positive sense of self, they are attacking me!" When going into adult life, this attitude will foster high reactivity to criticism from others (i.e., feedback that they are not perfect), and other people will tend to perceive they are trying to convince everyone of

their perfection. Other people of course resent this, and back away, which then in turn triggers the narcissistic individual's old memories of abandonment and indifference (Shapiro, 2001), restimulating their need to be perceived as perfect in the eyes of others (P. F. Kernberg et al., 2000). We posit that this was, in childhood, the only available defense against total abandonment.

Presentations of Narcissism in Treatment

The surface presentation of a client with narcissistic features does not always represent a full picture of the client's entire personality structure. The surface presentation very often is an *armor* that covers an *extremely vulnerable self*. This vulnerable self-state may be partially or wholly unavailable to conscious access. New *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; APA, 2013) criteria try to reflect this ambivalence, explaining that exaggerated self-appraisal may be inflated or deflated, or vacillate between extremes. In other words, narcissistic traits, although damaging to both the individual and others, are not necessarily present in the behavior of the individual at all times, and this can be confusing for clients, significant others, and therapists.

Gabbard (1989) states that the usual description of narcissistic personality disorder focuses on the "overt" qualities of narcissism (grandiosity, exploitation, arrogance, interpersonal problems, and rage) while omitting the less obvious and subtler "covert" characteristics (tendency to be shame sensitive, introverted, vulnerable, inhibited, and anxiety-prone). Although many narcissistic presentations are just *the cover* of a *vulnerable self*, generalizations must be avoided. There is a group of clients with severe narcissistic pathology who have entirely and strongly dissociated all early memories of abandonment and maltreatment, and consequently, these clients are unlikely to feel "bad" or "less," or have an inner experience of emptiness or hollowness. Instead, they may attempt to use therapy as a vehicle for manipulating significant others. A well-intentioned therapist might ask too many leading questions and misperceive a *false vulnerable self* and nonexistent early traumatic memories while failing to place sufficient emphasis on protecting others, such as family members, who might be in danger (Mosquera, 2012).

The "Closet Narcissist"

Another possibility is that narcissistic traits may only be evident after some time in treatment. Masterson (1981) defines the "closet narcissist" as a client who presents as humble, timid, shy, inhibited, and/or ineffective, only to reveal later in therapy the most elaborate fantasies of the grandiose self.

The "Unprincipled Narcissist"

In cases of evident maltreatment, resulting in legal procedures, some clients with narcissistic tendencies are referred to therapy. Other times, they are brought in by the same relatives (partners, parents) who have suffered the consequences of their character and are now forced to be treated. Often, it is not the person with narcissistic personality who comes in as the client. Instead, he or she comes in as the "collaborative" relative of a person who is seeking therapy because of various symptoms, and many of those symptoms may have resulted from the person's exigency and selfish demands.

In cases of people who are even less empathetic toward others and who can be described as antisocial individuals (such as the "unprincipled narcissist," Millon, 1996), therapy will likely be very difficult. The behavior of the unprincipled narcissist is characterized by an arrogant sense of self-worth, indifference to the well-being of others, and fraudulent and intimidating social manners. These individuals are aware that they exploit others and expect special recognition and consideration without assuming reciprocal responsibilities. They lack a genuine sense of guilt and have little social conscience. They maintain their relationships as long as they have something to win (Millon, 1996).

In some cases, they enjoy hurting others (Mosquera, 2007). We can think of these people as individuals who learned early in life to avoid attachment because this was always associated with emotional pain. They are difficult to treat because their devaluing defense is so deeply entrenched that has become their identity. In many such cases, the more realistic therapeutic intervention is for them to learn about the negative consequences of their behaviors or to protect others from them.

The "Elitist Narcissist"

Some people with narcissistic personalities present a more subtle profile, as the "elitist narcissist" (Millon, 1996), which was originally described by Reich (1949) as "phallic-narcissist." Sometimes they seem to be well-adjusted people, but because they talk excessively about themselves, they are prone to discrepancies between what they are and how they portray themselves. Unlike many others who are aware of this disparity, the "elitists" are completely

convinced of their wonderfulness. Instead of making an effort to acquire genuine qualifications and talent, much effort instead is geared toward persuading others of their specialness. They may be shocked, disappointed, and even angry when others do not reflect back their overly valued self-image. Many are social climbers who try to cultivate their sense of specialness and personal benefit by associating with those who have genuine achievements and recognition. In any activity they do, they invest their energy in advertising themselves, boasting their achievements, true or false, and trying that anything they have done looks amazing, better than anything done by others, and better than it actually is (Millon, 1996). In these cases, there may be an important history of ostentation, being the center of attention, exaggerated symptoms, great importance, and a desire to be different. These clients consider they have to be treated differently because they are special. Underneath this attitude, there is often a fragmentation of true identity or an extreme difficulty for emotional connection. One example is a middle-aged man who felt emotionally devastated when his wife, after years of feeling ignored, criticized, and humiliated by her husband, asked for a divorce.

The "Victimized Narcissist"

Self-defining as a "victim" can function as a substitute for a more comprehensive and realistic identity. The history of such a person may include extensive and early emotional neglect, but in their present life, they expect other people to fulfill their needs and give them what they never had. Many personalities with narcissistic traits end up building an identity around the idea that "everything bad has happened to me." This type of reasoning and way of "looking at life" (through an especially negative and very self-referential filter) usually generates great suffering and many adaptation difficulties for the person (Mosquera, 2008). The person's feeling of having been a victim is, in a sense, accurate in regard to childhood maltreatment, but this sense of victimization is misapplied to many present situations, resulting in repeated negative responses from others. The narcissistic piece of this clinical presentation is the sense of entitlement: "I have been treated badly in the past, so today I deserve special treatment." In this way, the pattern repeats itself; the victim identity paradoxically leads to revictimization because the client can only continue to perform this role (that feels familiar and essential for psychological survival) through abusive relationships.

A variant of this subtype of personality is a person who clings to a diagnostic label as a substitute identity.

This is a self-assessment of "being a difficult and special case." For example, a 52-year-old professor asked for an appointment stating that the therapist was lucky to evaluate him because he was the most severe case she would ever see in her life. This attitude can be a "cry for help," but it can also be a diagnostic signal to the therapist that the client may have a strong sense of entitlement and a feeling that it would be unfair to be held to normal expectations of responsibility.

Clients With a "Yes–But" Style

Some clients may present themselves with apparently low self-esteem and depression, which usually mobilizes attention and care from others. However, this attention and care never seems to be enough; it is like they need "something more," something they cannot find and could end up fulfilling them. These people ask for help, demand treatment, and come to appointments but present a strong ambivalence toward being helped and tend to do the opposite of the proposals they initially seem to accept (Mosquera, 2008). At a pragmatic communicative level, these negative verbalizations about themselves are an attempt to elicit supportive comments from others. Deep down, their beliefs are such as "I am above others," "my values are superior," and "injustice comes from the world and I am an undeserving victim." They usually attribute their problems to something external and present great difficulties in assuming their responsibility or focusing on what depends on them. Sometimes they present a passive-aggressive style, moving others to do things for them, to finally make those people feel ineffective because nothing is ever good enough.

The Tireless Caretaker or "Pleasing Narcissist"

Some clients are focused on achieving approval from others and are very vulnerable to criticism. All their behaviors are designed to show others an image of "extremely good person"; they seem to live "for" others and do not understand why others do not "give back." Although they seem to "enjoy" pleasing others, they actually expect something in return but have difficulties recognizing this and experience resentment and anger when the chosen ones do not respond as expected. They can construct an elaborated facade of "goodness" and are confused when they encounter negative reactions from others (Mosquera, 2008). There may be a kind of grandiosity in their assumption of responsibility for the feelings and behavior of everyone around them. This type

of individual may suffer a "narcissistic injury," and/or indignant anger, when others do not respond as expected to their goodness. This subtype can be a source of traumatization for their children who will often describe them in adulthood as "wonderful parents," although they may feel confused and guilty about having resentment toward these self-sacrificing but self-centered parents.

Challenges of Working With EMDR With the Client With Narcissism

For therapists who treat narcissism, it can be challenging to manage negative, countertransferential emotional reactions toward clients who are phobically avoidant of letting the therapist matter and have a knee-jerk reaction of blaming others whenever they encounter frustrations in life. These clients may say things that put the therapist on the defensive, such as "Why are you so sure you can help me?" or, as one client said, "My main problem is that other people do not act the way they should. How can EMDR help with that!?" The therapist may start a conversation on the variety of options to choose from when other people "do not act right," and the purpose of therapy can be to move toward one of those options (e.g., acceptance, or constructive, problem-solving conversation).

It is evident that this pattern of personality may initially prevent the client from engaging in effective EMDR processing of traumatic life experiences. The mindful stance proposed by Shapiro (2001) as a prerequisite to access and process a memory is not usually present in personality disorders, where early attachment disruptions did not allow for the full development of integration between cognitive, emotional, and sensorimotor processing levels. As a consequence, the person developed defensive mental structures to prevent unbearable contact with disturbance and vulnerability (Afifi et al., 2011; Bennett, 2006).

Activation of Defensive Mental Structures

For the client with narcissistic tendencies, these defensive mental structures tend to be activated quickly and automatically in response to any threat to the idealized false self. In our practices, we have seen that clients with narcissism have trouble seeing conflictual problems with other people realistically and identifying their own contribution to those problems. Instead, they are likely to quickly and almost automatically blame others, apparently to protect their idealized self-image.

Covert Narcissism

A narcissistic personality structure may be highly overt and evident to many of the people who observe the person with narcissism, or covert, and well hidden, except to those attempting to have an intimate relationship with the individual. How can the therapist detect covert narcissism? Overt narcissistic traits can be identified easily, but covert pictures are more difficult. A hidden narcissistic personality structure will usually become more evident in the client's excessive reaction to a criticism or shortcoming that is, in an objective sense, minor. Undetected narcissistic clients may try (because it is common for their pattern of functioning) to attract the therapist's attention and admiration by playing the role that he or she thinks the clinician would prefer. In addition, they may present easily solved problems and memories to solidify the connection with the therapist.

Projective Identification

Therapist working with clients with narcissistic features should be aware of certain kind of projective identification, in which the therapist is idealized by the client, and then the therapist takes in the client's projection of idealization and begins to act out the idealized projection as a countertransference. The client's feeling in these sessions would be one of "I am a special and superior person, and you are my special and superior therapist." This can be a setup for therapy to fail if the therapist becomes invested in this idealized image of self, or if the client, because of this mutual idealization, is reluctant to reveal personal flaws. This pattern of projective identification may also have occurred in many of the client's other relationships. For the client with narcissism, the "top 10 disturbing events" may be situations where others failed to mirror the client's idealized self, or situations where that ideal was somehow no longer tenable—something occurred that revealed the client to be less than superior.

Lengthy Treatment

Because of the complexity of narcissistic personalities, a long process of dismantling the dysfunctional personality structure will usually be needed (Mosquera, 2012). The therapist must accompany this dismantling with a high degree of attunement and attentiveness to the emotional safety of the client. We are often teaching our clients with narcissism to accept the reality of another person's accurate attunement—something that the client did not receive nearly

enough of during childhood. The therapy process is often necessarily slow because underneath the narcissistic exterior, there may be an extreme reactivity and vulnerability to feelings of abandonment or feelings of being unfairly attacked or shamed.

When or Why Do Individuals With Narcissism Come to Therapy?

People with narcissistic qualities or traits may have tremendous unhappiness in their lives but are often reluctant to enter psychotherapy. There may fear being in a situation of evaluation regarding another person, revealing personal information which might differ from their idealized self-image, or being in situations in which uncensored truth telling is the norm. Clients with narcissism, because of their specific personality characteristics, usually do not come to therapy with a good understanding of their problems or the origins of the problems. More often, these individuals are brought to treatment by others who suffer the consequences of their self-centered attitudes and behaviors. They may ask for professional help because of the following reasons:

- Lack of mirroring (lack of others mirroring them *as they are expecting*)
- Couple problems or intimacy issues
- Work problems (generally with coworkers or employees)
- As relative of a designated client, who is suffering because of their narcissist selfishness, exploitation, or lack of empathy; sometime they even "send" their spouses or family members to therapy so they can be improved or "fixed"

Many clients with these narcissistic characteristics will only resort to professional help after crashing with reality (Mosquera, 2012), which sometimes causes depression. This usually happens when something comes along that makes the idealized image untenable; something "pops the bubble"—a narcissistic injury (Knipe, 1998).

EMDR Therapy for Clients With Narcissism

In the EMDR approach to psychotherapy, psychological problems are viewed as being mainly caused by the cumulative effect of unresolved traumatic and adverse experiences (Shapiro, 2001, 2007). EMDR therapy has been shown to be an effective, efficient, and well-tolerated treatment for posttraumatic stress disorder (PTSD; Bisson & Andrew, 2007; Foa, Keane, Friedman, & Cohen, 2009; Ursano et al., 2004) and is effective for both adult and childhood onset PTSD

(Adler-Tapia & Settle, 2009; Field & Cottrell, 2011; Korn, 2009; van der Kolk et al., 2007).

In EMDR therapy, the client is directed to mindfully notice what happens to representations of disturbing or dysfunctional visual images, self-referencing negative thoughts, emotions, sensations, action urges, and self-statements while attending to a series of sets of bilateral stimulation (BLS) involving alternating eye movements, taps, or auditory tones (Leeds, 2009; Shapiro, 2001). EMDR uses an eight-phase approach and addresses past memories, current triggers, and future situations. To assess changes during reprocessing, two scales are used: Subjective Units of Disturbance (SUD) scale and Validity of Cognition (VOC) scale.

In the first two phases, the therapist collects client history, builds therapeutic alliance, and prepares the client for the reprocessing phase. Phases 3 through 7 focus on reprocessing a targeted experience. In Phase 3, the client identifies a representative image for the target, related negative and positive self-statements, emotions, and physical sensations. The client rates the validity of the positive cognition (VOC: 1 = *not true*, 7 = *totally true*) and the subjective disturbance of the emotion (SUD: 0 = *no disturbance*, 10 = *worst possible disturbance*). During Phase 4, client notices how elements change while attending to alternating BLS (generally eye movement). Phase 4 ends when the level of disturbance (SUD) reaches 0. In Phase 5, BLS is applied to reinforce the linkage between the experience and the positive statement until the VOC reaches 7. In Phase 6, clients report any residual sensations that need to be reprocessed. In Phase 7, the clinician makes sure the client reaches closure. Clients are asked to take internal notes, understanding these events experiences as a part of the process. In Phase 8, the clinician reevaluates the effects of the reprocessing and monitors the client's progress.

Performing EMDR procedures may be a challenge when working with complex personality structures characterized by rigid defensive patterns and separate self-states. Personality parts may function very separately and may not have full conscious access to each other and also may have difficulty in having full "realization" (van der Hart et al., 2006) of how the present is separate and different from the past (P. F. Kernberg et al., 2000). This failure of realization can make erroneous projections onto others more likely, and this can cause significant problems in relationships, including the relationship with a therapist. The therapist must pay attention to these distortions because they occur in the therapeutic relationship.

The Therapeutic Plan: Target Selection and Sequencing

Goal of Treatment. Investment in an overly positive image of self can dominate a person's sense of self, or can simply be a state of mind that arises, to varying degrees in certain specific circumstances. Whether the investment is large or small, there can gradually be a shift in therapy from emotional investment in the "false self" to being comfortable with simply being one's "real self." The illusion is given up, and there is a trade-off for this loss: an increased sense of groundedness and coherence within the self as well as an opening for real connections with other people. A person can come to accept: "I'm not wonderful, and actually that's okay, and it is a relief to know that I'm not terrible. It's okay for me to just be who I am." It is rewarding for the individual to discover simple permission to be human and to be aware of the humanness of others. Therapy with these clients is, by necessity, slow and gradual.

Initial Targets. Masterson (1981) recommends beginning the treatment of an individual with narcissistic traits by "mirroring narcissistic vulnerability." In other words, initial relationship building occurs as the therapist empathetically reflects the client's disturbance associated with those times when the false self was not supported by others or was revealed to be selfish, unrealistic, embarrassing, or inappropriate in some way. For example, the therapist can say, "I can see that, when that happened, it was very upsetting. Can you tell me more about what you were feeling in reaction to that?" Consistent with this approach, an EMDR therapist might suggest that targeting begin with events that contain *more accessible* disturbance and those that the client can *easily identify as negative and personally problematic* such as current triggers or recent events. A recent narcissistic injury (i.e., an event that severely undermined the client's distorted and overly positive false self) may be a highly accessible target, one containing feelings of humiliation, helpless anger, or other negative affect. This situation might provide a good opportunity to introduce the client to EMDR processing procedures and explain the benefits of this therapeutic approach. Many such situations are typically available in the initial presentation of a person with narcissistic traits because unrealistic self-centeredness, self-congratulation, and entitlement tend to invite the negative response of others. Unrealistic self-idealization, occurring to a greater or lesser extent, will eventually be likely to result in humiliation—a "crash with reality."

Targeting First, Worst, and Recent Narcissistic Injuries. If the client has enough trust in the therapist, these types of hurtful situations can be revealed and discussed, and if possible, the first, worst, and most recent examples of the particular type of narcissistic injury can be identified. These narcissistic injury situations may not directly access the core experiences from early childhood, but they are likely to be much more easily accessed with emotional safety and less challenge to the stability of the therapy relationship. Because several of these situations are accessed and successfully processed, over a period of time, the therapeutic alliance will be strengthened, leading ultimately to the client being able to work directly with core childhood experiences of parental disengagement, emotional abandonment, and/or abuse.

It is useful for some clients to present this type of work as a "stress relief" procedure. For example, clients may come to therapy complaining about how someone else did not "act right," and this was stressful for them. The therapist can say, "This might help this situation to not bother you so much, even though it may not take away all the stress you are feeling."

As the stress of these narcissistic injuries is lessened and the client is able to remember these situations with more clarity and less disturbance, there can be a subtle but important shift—a shift away from focusing on one's own needs, one's own sense of entitlement, toward seeing others not so much as objects but as real and separate people. Empathy—interest and engagement toward the separate needs and experiences of others—can be presented to the client as a solution to a previously confusing problem: "Why is it that other people do not respond positively to me when I am so impressive?"

Little by little the client with narcissistic traits may come to see, and feel, the importance of empathy toward others and how this is the key to getting along nicely and successfully with other people. As this occurs, the client may also experience a shift in the very definition of the self, toward a more realistic and balanced self-perception. One client said, "I can see now that I'm not so good, and I'm not so bad!"

Targeting Initial Positive Events That Created Self-Idealization. Once the client is able to begin having this type of felt insight, the door may open to going back and specifically targeting the positive events that created the self-idealization in the first place—that is, specifically targeting the positive affect associated with those events. Examples of this can be memories of being indulged by a parent, present-day situations where the individual satisfied an obsessive need

to gain the parents' admiration in today's world, or a time when the client was able to win the admiration of other people. Typically, as these instances are targeted, the defensive purpose of self-idealization will become clearer—that is, the overly positive self-concept was a way of shifting away from, or not feeling, the emotional pain of neglectful or traumatic events. Conversely, it may be useful to identify and target times in the past when there was a narcissistic injury—something happened that made the narcissistic self-concept untenable—and the person felt humiliated or disgraced at least for a short time until the self-concept of perfection was restored. These are all examples of targeting memories with dysfunctionally stored positive affect, memories which then form the foundation of the idealization defenses preventing full access to negatively balanced memories of parental abuse or nonengagement. Generally, it is only after working with several examples of how idealization defenses began, once there is a strong alliance and the client has gained a sense of mastery in working with uncomfortable memories, that we can proceed with trauma reprocessing of the core memories (Mosquera, 2012).

Future Templates. Future templates should be used to complete the three-prong approach and solidify the results achieved after the processing of past memories and present triggers.

Phase 1 in EMDR Therapy With Individuals With Narcissism: History Taking

During Phase 1, it will be particularly necessary to establish a strong therapeutic connection through repeated accurate empathetic understanding on the part of the therapist. We want the client to have a clear sense of "My therapist really gets it! My therapist gets who I am!" The therapist's role is to help the client with narcissism to develop curiosity about why others often react negatively and in this way begin to glimpse that their inflated self-concept is unrealistic and self-defeating. It is important, in discussing the client's notions of superiority and entitlement, that the therapist use words that are sensitive to the client's underlying vulnerability and self-idealization defenses, so as to ensure that feelings of shame or attack do not arise (Mosquera, 2012). The client's entitled, superior false self (Winnicott, 1965), although appearing strong and robust, is typically very fragile, a thin veneer covering feelings of emptiness and often enormous self-doubts. The client may be "rude," not showing much awareness of the insulting implications of something

that is said or the effects of a certain statement on another person. In the initial sessions, it is probably best for the therapist to avoid responding to this rudeness with premature interpretations. In some cases, even verbal attacks on the therapist may require a minimal response—these attacks may be a nonconsciously motivated "test" of whether the therapist is able to maintain his or her self-esteem (i.e., the client needs to know the therapist has a sufficiently resilient sense of self) in the face of attacks. The client may be therapeutically surprised by this resilience in the therapist—resilience that may contrast sharply with the angry response the client has previously received from other people.

Clients will not benefit from therapy if they drop out, so therapists should be alert to the dangers of confronting "acting out" behavior too early. A certain amount of positive therapeutic relationship is necessary for confrontation to be effective, and the bigger the confrontation, the stronger the relationship needs to be. Once the client knows that the therapist is "on my side," and working for the client's best interest, then confrontation, delivered with compassion and empathy, will be more effective. In other words, the therapist must be careful not to confront the client's material in the first few sessions, no matter how selfish it might seem (unless, of course, the clients behavior is about to cause something very damaging). Initial sessions may be filled with defenses, and this may continue over many sessions because the client needs to prove to himself or herself over and over again that the therapist will not retaliate in the way many other people in the client's life have done. This does not mean that the therapist should be phony, just highly tuned in to the danger of the client misinterpreting, truly misunderstanding, negative feedback. Paradoxically, this approach then can result in the client becoming more relaxed and willing to disclose potentially vulnerable aspects of self.

Phase 2 of EMDR Therapy: Preparation

During Phase 2 of EMDR therapy, the clinician should avoid formulating phrases that imply we see the client as in need of prolonged stabilization because this could lead to the activation of defenses and interfere with treatment.

Psychoeducational Interventions. The preparation phase will be a long and patient process of dismantling the many defensive layers present in clients who present narcissistic traits. Psychoeducation is often

very helpful in describing how defenses can develop as an adaptation to a difficult childhood environment. Defenses are explained as an attempt to help the self, not a personal flaw or failing. Early traumas may be identified, but, given the fragility of the client's initial personality structure, generally it will not be a good idea to begin with the worst episodes or trauma reprocessing because there are many walls to take down before we can reach that point (Mosquera, 2012).

Psychoeducation and collaborative reflection, along with the reformulation of the client's problems and history, are needed prior to identifying dysfunctionally stored relevant memories that are feeding the narcissistic structure. After this psychoeducational process, clients are able to think very differently about their situation. Let us see some examples (Mosquera, 2008):

Peter: My parents always have treated me like a special being, I believed I was unique, superior . . . going out into the real world was very traumatic for me. I wondered why they (others) didn't realize how wonderful I was. With time, I realized it was me who didn't fit in and, if I was so special, why didn't my relationships work out? Why did I always have problems with others? The attitude of high-handedness didn't help, but I was not aware of this and I looked down on others for not being able to see my worth . . . I was so wrong . . . I never thought of the possibility that my attitude could be influencing everything else, I believed I should be treated in a special way just because I was me, how embarrassing . . . (p. 8)

Susan: Now, with distance, I think my parents have loved me dearly but have harmed me terribly. I do not say this resentfully, like I used to, but as something that is real, something that they have not been able to offer me in my education, basic principles of relationship with others, the importance of taking others into consideration, and how enriching it can be to get to know other points of view. I would've never thought this before. (p. 8)

John: I have always felt contempt toward others, their interests, their opinions, their criteria . . . always thinking that they weren't at my conversational level . . . how absurd . . . I have spent years feeding the anger and the feeling of injustice, searching for every little detail that could justify my position . . . always comparing myself to others. I feel that I've wasted many opportunities along the way . . . nothing was good enough for me, any job looked "too small" for me . . . if it wasn't too little money it was too little rank, if it wasn't this, it was the coworkers

and bosses who were incompetent, and if not, it was that they didn't value me or treated me like "I deserved." I have let many opportunities go by, but the difference is that now I feel that I have lost those opportunities, not that "they have taken them away from me" or that I have been sabotaged . . . I used to think that others had the problem, now I'm aware the problem was in me . . . (p. 8)

The Introduction of Bilateral Stimulation in Phase 2 for Clients With Narcissism. BLS can be used in Phase 2 to enhance interventions and to process non-traumatic targets, such as defenses or relational problems. The main issue at this point is to not be misled by the client's apparent security, stability, and control and overestimate the client's resilience. Hidden fragility can be high, and the client may become dismantled by processing defenses that are still needed to maintain a sense of stability and control.

Stabilization Strategies. Clients presenting narcissistic features need to learn to develop abilities for emotion regulation or interpersonal relationships. This information should be carefully introduced because they can be hypersensitive to messages that can suggest that they are not superior, capable, or skillful in everything Working on self-differentiation may be needed as in other personality disorders (Mosquera, 2012; Mosquera & Gonzalez, 2014).

Even interventions that are usually stabilizing, such as resource installation (Leeds, 2009) or working with self-care patterns (Gonzalez & Mosquera, 2012; Mosquera & Gonzalez, 2014), should not be used until the client is able to progress in reflective thinking and attain a more realistic sense of self. When the client improves in his accurate, objective assessment regarding his problems, healthy resources and self-care patterns may be installed.

Working With Idealized Positive Memories. The work on defenses (Knipe, 1998, 2005, 2014) targeting positive affect memories related to the false self can be useful for a client who has become aware of the self-defeating nature of a distorted idealization of self. For example, a 31-year-old male client was distressed that his live-in girlfriend was not sufficiently impressed by his high income. At times, her statement that his income level did not really matter to her confused him, and at other times, he interpreted her statements to mean that she did not love him. It was helpful to him to go back to very specific memories of how his parents had given him the message that earning power equals worthiness. This message had been given in the context of parental noninvolvement

with him and even intense criticism at other times. Thus he had learned, "The way to be connected to another person is to make a lot of money and then be regarded as worthy. If my earning power is not acknowledged, that means the other person is indifferent to me." It was helpful for him to target the positive feeling associated with a specific memory—a time when he had told his parents of his high salary. The positive affect of this memory, initially a "10" (on a 0–10 scale) diminished with repeated sets of BLS, and this result was accompanied by many images of childhood loneliness. When these were targeted, using EMDR Phases 3–7, this man reached a state of resolution and new appreciation for the loving message of acceptance that his girlfriend had been trying to give him. This approach (called the level of positive affect [LOPA] method; Knipe, 1998, 2014) should be used with these clients only after a sufficiently strong therapeutic relationship has been established because it involves a high level of client self-disclosure. An experienced therapist might think, "Is this a good idea . . . reducing the strength of a psychological defense? Won't that leave the client even more vulnerable to disturbing posttraumatic memories and feelings?" We have found that, typically, this is not the case. When the origins of the client's idealized false self are targeted, within the context of a solidly established therapeutic relationship, the strength of the narcissistic defense tends to diminish, along with a parallel reduction in the intensity of the underlying traumatic memory material. Thus, this material can be safely targeted using standard EMDR procedures for troubling memories.

Idealization can be of self or others. For example, a client was in danger because of her idealized attitude about her primary relationship with a problematic boyfriend. Although he was in prison for almost killing her, she was in denial of the situation and was hanging on to the idealized moments spent with him. By targeting the best idealized moment, she was able to realize the situation.

Working With Parts and Dissociation. If the family environment was extremely neglectful, nonengaging, and/or abusive, there may be severe divisions within the personality structure (Afifi et al., 2011; Bennett, 2006; Lyons-Ruth, Dutra, Schuder, & Bianchi, 2006; Mosquera, 2012; van der Hart et al., 2006). There may be an amnesic separation between the idealized, positive self-state, and other self-states that hold memories of lonely abandonment or abuse.

Understanding clients with narcissism as having different self-states or parts (e.g., a false grandiose self, a vulnerable child, an aggressive protector part) may help the client understand the underlying structure and plan interventions. The client may have conscious access to these parts, or memories that activate these parts, and if that is the case, and the client is able to obtain sufficient emotional safety with the therapist, these memories can be targeted using standard EMDR procedures. The sequence of targeting should be assessed according to the client's ongoing need for emotional safety and stability as well as the therapy contract. But if there is a comorbid dissociative disorder—that is, a history of disorganized attachment in childhood and dissociative separation between personality parts—the course of treatment will need to be informed by a more "progressive approach" of working with dissociative phobias and the internal system of parts (Gonzalez & Mosquera, 2012; van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013).

Phase 3: Assessment

During Phase 3, several specific issues may come up when working with this population. It seems that clients with a narcissistic style do not like being asked to rate their experiences numerically, such as what it is done with the VOC and SUDs, perhaps because numbers compel clients to take a close a look at their own inner experience.

Problems in Phase 3 are usually related to cognitions. In initial targeting, the therapist should not push too hard to obtain a self-referencing negative cognition (NC). It may be helpful to allow the client to express NCs about others (or even ask about them), prior to asking for a self-referencing NC. Accepting cognitions as "It still bothers me" (very mild compared to other NCs, but one that most people with narcissism are likely to accept) can be useful (Knipe, 1998). The positive cognition (PC) in this instance can be something equally mild: "It doesn't bother me anymore." Regarding PCs, we should be careful not to accept an idealized PC such as "I'm the best" or "I'm superior," even though it is something a client may mention when asked about the desired PC (Mosquera, 2012). One issue here is that Phase 3 questions may be given different answers by the different and separate personality parts. One response may be coming from the part of the client carrying the disturbance and another response may come from the idealized false self. For example, a client may identify a disturbing memory and an accompanying NC of "That really bothers me!" Then, the client may say that an associated PC, "That doesn't bother me at all," has a VOC score of "Seven!"

Phase 4: Desensitization

Clinicians should keep in mind that according to the AIP model, we expect focused sets of BLS to aid in linking adaptive information, but this does not mean these associations will always be experienced as positive. For example, a client with a self-centered blaming defense may become increasingly aware of personal blame and responsibility for difficult events. For example, "I am guilty" is more adaptive than "others are the cause of my problems" in situations where the client actually has some responsibility for what has happened. Processing may appear to be "a reversal processing" going from positive (idealized) to negative (realistic). This possibility illustrates why a strong and trusting therapeutic alliance is so necessary in working with clients who have narcissistic characteristics. When therapy proceeds in a helpful and appropriate manner, the client is necessarily revealing enormous fragility and vulnerability. Therapist must be careful to avoid words that might conceivably have implications of shaming, and the client's disinvestment from the idealized false self must proceed at a pace the client can tolerate.

Sometimes therapists may need to take an active stance to guarantee that all emotions are included in the desensitization phase. For example, in the client's history, fear or sadness may not have been permitted. The client was only allowed to be a perfect-idealized child, without the feelings, or other behaviors, that parents could not tolerate. The therapist can introduce interweaves such as "allow yourself to feel ALL your feelings" or "let it out, it's ok."

Phase 5: Installation

Some clients have problems searching for a PC because they erroneously think they need to be convinced of this belief before starting EMDR reprocessing. For these clients, the therapist can say, "I wouldn't expect that you word have a high (VOC) score at the beginning of this work. If your score is a 1, 2, or 3, that just means we are working on the right thing."

In some cases, this phase can be complicated because clients from neglectful or traumatic early environments may lack reality-based positive networks with which to connect. Others do not have experiences of shared positive affect with their childhood caregivers, and they may feel disturbance with positive self-statements caused by the lack of positive affect tolerance (Leeds, 2009). These clients may simply be unfamiliar with the satisfactions of empathetically engaging with other people because these experiences were not in their personal histories, or,

what is worse, true engagement with others was systematically punished or ignored.

An important "teaching moment" often occurs within Phase 5, when the client comes to realize that a PC of superiority or entitlement is actually not realistic or sustainable. At this point, the therapist may suggest a more appropriate PC. For example, instead of a defensive PC, "I am untouchable/unbreakable," the therapist can suggest a more reality-based PC, "I can protect myself."

Phase 6: Body Scan

Within Phase 6, it seems there are fewer variations from the usual protocol. Some clients with narcissistic features have learned to dissociate certain body sensations, and these may be more available to consciousness following the earlier EMDR phases. For example, after Phases 4 and 5, a client might report more physical tension, or tiredness, or hunger (if dissociation of hunger was part of the initial false self, as sometimes occurs with anorexic clients). The therapist should be alert to the possibility that these physical sensations may be the beginning of additional traumatic information channels and ensure that the client is able to adequately contain any emerging information before leaving the session.

Phase 7: Closure

It is often better to leave a target incomplete and end a session with adequate and safe closure than to *push too much*. Some targets—both of self-idealization memories and of trauma/neglect memories—may require several sessions. In addition to the usual closure procedures focused on calming sensations of tension, the authors also recommend questions such as "What did you figure out here today that helps you?" or "As you leave here today, what is it that you want to be sure to remember—something that will be really helpful for you?"

Phase 8: Reevaluation

Clients initially showing narcissistic traits may need additional time and sessions to consolidate the new understandings obtained during the sessions focused on memory processing. Within one session, clients may be able to develop clear understanding of the ways in which their overly positive, idealized picture of self has been a problem in achieving their larger goals. In addition, clients may experience an emotional disinvestment in the need to be superior or entitled. Nevertheless, between sessions, they may return to defensive ways of relating to others and idealizing

the self. It may be necessary, over extended therapy sessions, to identify and target additional events that were the initial basis for inappropriate self-idealization. There may be memories of pampering at age 7 years, superior performance regarding a sibling at age 9 years, feelings of superiority in regard to high school classmates, ignoring the feelings of others in their current relationships or employment, and so forth. As each of these dysfunctional positive affect targets is resolved, the person's emotional investment in the narcissistic false self is likely to diminish. As this occurs, it is also usually important to draw the client's attention to the increased satisfaction that is now available regarding engagement with other people—empathetic engagement without the competitive aspect.

The reevaluation phase is crucial for an adequate reprocessing of targets. It is important not to lose focus and avoid "target hopping." The client might bring different aspects to work on, but it is important to stay on track.

Some cases can evolve slowly, especially the ones that *have never been in therapy before*, and therefore may not, at first, have a real core identity. In time, as we remove armors and layers of defense, a strong sense of "This is who I really am!" can emerge.

These cases may need reconstructive work after processing sessions, where clients will learn to look inside, to recognize who they actually are, and how to function from this new perspective. Clients may apparently become worse during those moments when they come in touch with their real self without defensive structures and are still lacking a real identity. During this part of the therapy, when certain core issues are being processed, working with self-care patterns becomes relevant as a referent for reconstructing a new way of relating to the real self. Resource development and installation is also important to create and/or reinforce adaptive and healthy aspects of the personality (e.g., empathetic engagement with others). It is important for the therapist to notice and appreciate the client's positive changes and interweave this positive recognition with the difficult work of relinquishing long-held defenses and directly targeting disturbing memories.

Conclusion

Narcissistic traits may be a consequence of a distorted and overly idealized self-concept, which in turn has resulted from many different early situations, including excessive praising and overprotection. In addition, this idealized self-concept is related to the need to create psychological defenses to prevent the full emergence of memories of severe neglect and abuse. For an effective EMDR therapy process to take place, it is necessary to understand the specific pathway that each client has traveled from their specific early experiences to their real present problems.

Effective treatment of narcissism involves actively resonating with the client's self-definition and the way the client perceives the presenting problem; engendering self-reflection in the client during the preparation phase; identifying the many possible therapy detours and dead ends that can result from overactivation of defense; identifying and treating core experiences of early nonengagement, neglect, and trauma that may have been initially covered (i.e., blocked from awareness) by defenses; identifying and empathetically correcting distortions in the client's perception of the therapist; and avoiding nontherapeutic countertransference reactions originating within the therapist.

References

Adler-Tapia, R., & Settle, C. (2009). Evidence of the efficacy of EMDR with children and adolescents in individual psychotherapy: A review of the research published in peer-reviewed journals. *Journal of EMDR Practice and Research*, *3*(4), 232–247.

Afifi, T. O., Mather, A., Boman, J., Fleisher, W., Enns, M. W., MacMillan, H., & Sareen, J. (2011). Childhood adversity and personality disorders: Results from a nationally representative population-based study. *Journal of Psychiatric Research*, *45*(6), 814–822.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Battle, C. L., Shea, M. T., Johnson, D. M., Yen, S., Zlotnick, C., Zanarini, M. C., . . . Morey, L. C. (2004). Childhood maltreatment associated with adult personality disorders: Findings from the Collaborative Longitudinal Personality Disorders Study. *Journal of Personality Disorders*, *18*, 193–211.

Bennett, S. (2006). Attachment theory and research applied to the conceptualization and treatment of pathological narcissism. *Clinical Social Work Journal*, *34*(1), 45–60.

Bierer, L. M., Yehuda, R., Schmeidler, J., Mitropoulou, V., New, A. S., Silverman, J. M., & Siever, L. J. (2003). Abuse and neglect in childhood: Relationship to personality disorder diagnoses. *CNS Spectrum*, *8*, 737–754.

Bisson, J., & Andrew, M. (2007). Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database Systematic Review*, (3), CD00338.

Cai, H., Kwan, V., & Sedikides, C. (2012). A sociocultural approach to narcissism: The case of modern China. *European Journal of Personality*, *26*, 529–535.

Campbell, W. K., & Foster, C. A. (2002). Narcissism and commitment in romantic relationships: An investment model analysis. *Personality and Social Psychology Bulletin*, *28*, 484–494.

Cohen, L. J., Tanis, T., Bhattacharjee, R., Nesci, C., Halmi, W., & Galynker, I. (2014). Are there differential relationships between different types of childhood maltreatment and different types of adult personality pathology? *Psychiatry Research*, *215*(1), 192–201.

Collishaw, S., Pickles, A., Messer, J., Rutter, M., Shearer, C., & Maughan, B. (2007). Resilience to adult psychopathology following childhood maltreatment: Evidence from a community sample. *Child Abuse and Neglect*, *31*, 211–229.

Cramer, P. (2010). Young adult narcissism: A 20 year longitudinal study of the contribution of parenting styles, preschool precursors of narcissism, and denial. *Journal of Research in Personality*, *45*(1), 19–28.

DeWall, C. N., Pond, R. S., Campbell, W. K., & Twenge, J. M. (2011). Tuning in to psychological change: Linguistic markers of psychological traits and emotions over time in popular U.S. song lyrics. *Psychology of Aesthetics, Creativity, and the Arts*, *5*, 200–207.

Field, A., & Cottrell, D. (2011). Eye movement desensitization and reprocessing as a therapeutic intervention for traumatized children and adolescents: A systematic review of the evidence for family therapists. *Journal of Family Therapy*, *33*(4), 374–388.

Foa, E., Keane, T., Friedman, M., & Cohen, J. (Eds.). (2009). *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York, NY: Guilford Press.

Foster, J. D., Campbell, W. K., & Twenge, J. M. (2003). Individual differences in narcissism: Inflated self-views across the lifespan and around the world. *Journal of Research in Personality*, *37*, 469–486.

Gabbard, G. (1989). Two subtypes of narcissistic personality disorder. *Bulletin of the Menninger Clinic*, *53*, 527–532.

Gibb, B. E., Wheeler, R., Alloy, L. B., & Abramson, L. Y. (2001). Emotional, physical, and sexual maltreatment in childhood versus adolescence and personality dysfunction in young adulthood. *Journal of Personality Disorders*, *15*, 505–511.

Gonzalez, A., & Mosquera, D. (2012). *EMDR and dissociation. The progressive approach*. Madrid, Spain: Ediciones Pléyades.

Grover, K. E., Carpenter, L. L., Price, L. H., Gagne, G. G., Mello, A. F., Mello, M. F., & Tyrka, A. R. (2007). The relationship between childhood abuse and adult personality disorder symptoms. *Journal of Personality Disorders*, *21*, 442–447.

Hamamura, T. (2012). Are cultures becoming individualistic? A cross-temporal comparison of individualism-collectivism in the United States and Japan. *Personality and Social Psychology Review*, *16*, 3–24.

Johnson, D. M., Shehan, T. C., & Chard, K. M. (2004). Personality disorders, coping strategies, and posttraumatic stress disorder in women with histories of childhood sexual abuse. *Journal of Child Sexual Abuse*, *12*, 19–39.

Johnson, J. G., Cohen, P., Brown, J., Smailes, E. M., & Bernstein, D. P. (1999). Childhood maltreatment increases risk for personality disorders during early adulthood. *Archives of General Psychiatry*, *56*, 600–608.

Johnson, J. G., Cohen, P., Chen, H., Kasen, S., & Brook, J. S. (2006). Parenting behaviors associated with risk for offspring personality disorder during adulthood. *Archives of General Psychiatry*, *63*, 579–587.

Johnson, J. G., Smailes, E. M., Cohen, P., Brown, J., & Bernstein, D. P. (2000). Association between four types of childhood neglect and personality disorder symptoms during adolescence and early adulthood: Findings of a community-based longitudinal study. *Journal of Personality Disorders*, *14*, 171–187.

Jonason, P. K., Lyons, M., & Bethell, E. (2014). The making of Darth Vader: Parent–child care and the Dark Triad. *Personality and Individual Differences*, *67*(2014), 30–34.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York, NY: Aronson.

Kernberg, P. F. (1998). Developmental aspects of normal and pathological narcissism. In E. F. Ronningstam (Ed.), *Disorders of narcissism: Diagnostic, clinical and empirical implications* (pp. 103–120). Washington, DC: American Psychiatric Association.

Kernberg, P. F., Weiner, A. S., & Bardenstein, K. K. (2000). *Personality disorders in children and adolescents*. New York, NY: Basic Books.

Knipe, J. (1998). It was a golden time: Healing narcissistic vulnerability. In P. Manfield (Ed.), *Extending EMDR* (pp. 232–255). New York, NY: Norton.

Knipe, J. (2005). Targeting positive affect to clear the pain of unrequited love: Codependence, avoidance and procrastination. In R. Shapiro (Ed.), *EMDR solutions* (pp. 189–211). New York, NY: Norton.

Knipe, J. (2007). Loving eyes: Procedures to therapeutically reverse dissociative processes while preserving emotional safety. In C. Forgash & M. Copeley (Eds.), *Healing the heart of trauma and dissociation* (pp. 181–226). New York, NY: Springer Publishing.

Knipe, J. (2014). *EMDR toolbox: Theory and treatment for complex PTSD and dissociation*. New York, NY: Springer Publishing.

Kohut, H. (1971). *The analysis of the self: A systematic approach to the psychoanalytic treatment of narcissistic personality disorder*. New York, NY: University of Chicago Press.

Konrath, S. H., O'Brien, E. H., & Hsing, C. (2011). Changes in dispositional empathy in American college students over time: A meta-analysis. *Personality and Social Psychology Review*, *15*, 180–198.

Korn, D. (2009). EMDR and the treatment of complex PTSD: A review. *Journal of EMDR Practice and Research*, *3*(4), 264–278.

Kowalski, R. M. (2001). *Behaving badly: Aversive behaviors in interpersonal relationships*. Washington, DC: American Psychological Association.

Leeds, A. M. (2009). *A guide to the standard EMDR protocols for clinicians, supervisors, and consultants*. New York, NY: Springer Publishing.

Livesley, W. J., Jang, K. L., Jackson, D. N., & Vernon, P. A. (1993). Genetic and environmental contributions to dimensions of personality disorder. *American Journal of Psychiatry*, *150*(12), 1826–1831.

Lobbestael, J., Arntz, A., & Berstein, D. P. (2010). Disentangling the relationship between different types of childhood maltreatment and personality disorders. *Journal of Personality Disorders*, *24*, 285–295.

Luntz, B. K., & Widom, C. (1994). Antisocial personality disorder in abused and neglected children grown up. *The American Journal of Psychiatry*, *151*, 670–674.

Lyons, M., Morgan, K., Thomas, J., & Al Hashmi, A. (2013). Patterns of parental warmth, attachment, and narcissism in young women in United Arab Emirates and the United Kingdom. *Individual Differences Research*, *11*(4), 149–158.

Lyons-Ruth, K., Dutra, L., Schuder, M. R., & Bianchi, I. (2006). From infant attachment disorganization to adult dissociation: Relational adaptations or traumatic experiences? *Psychiatric Clinics of North America*, *29*(1), 63–viii.

Masterson, J. F. (1981) *The narcissistic and borderline disorders. An integrated developmental approach*. New York, NY: Routledge.

Millon, T. (1990). The disorders of personality. In L. A. Pervin (Ed.), *Handbook of personality* (pp. 339–370). New York, NY: Guilford Press.

Millon, T. (1996). *Disorders of personality: DSM-IV and beyond* (2nd ed.). New York, NY: Wiley.

Mosquera, D. (2007). *Desmontando corazas. El trastorno antisocial aprendido: Un mecanismo de defensa extremo*. [Removing shields: The antisocial learned: A defense mechanism end] Madrid, Spain: Ediciones Pléyades.

Mosquera, D. (2008). Personalidades narcisistas y personalidades con rasgos narcisistas. *Revista Persona*, *8*(2). Buenos Aires, Argentina: Instituto Argentino para el Estudio de la Personalidad y sus Desórdenes.

Mosquera, D. (2012). *Narcissistic personalities, trauma and EMDR*. Paper presented at the National EMDR Congress, Holland, The Netherlands.

Mosquera, D. (2013, June). *Understanding and treating narcissistic personality disorder with EMDR*. Paper presented at the 14th EMDR Europe Association Conference, Geneva, Switzerland.

Mosquera, D., & Gonzalez, A. (2011). Narcissism as a consequence of trauma and early experiences. *ESTD Newsletter*, *1*(2), 4–6.

Mosquera, D., & Gonzalez, A. (2014). *Borderline personality disorder and EMDR therapy*. Madrid, Spain: Ediciones Pléyades.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex, and the birth of the self*. New York, NY: Norton.

Reich, W. (1949). *Character analysis* (3rd ed.). New York, NY: Farrar, Straus, & Giroux.

Rettew, D. C., Zanarini, M. C., Yen, S., Grilo, C. M., Skodol, A. E., Shea T., . . . Gunderson, J. G. (2003). Childhood antecedents of avoidant personality disorder: A retrospective study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42*, 1122–1130.

Segrin, C., Woszidlo, A., Givertz, M., & Montgomery, N. (2013). Parent and child traits associated with overparenting. *Journal of Social and Clinical Psychology*, *32*(6), 569–595.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing. Basic principles, protocols and procedures* (2nd ed.). New York, NY: Guilford Press.

Shapiro, F. (Ed.). (2007). *EMDR as an integrative psychotherapy approach* (2nd ed.). Washington, DC: American Psychological Association.

Stone, M. H. (1993). *Abnormalities of personality: Within and beyond the realm of treatment*. New York, NY: Norton.

Tartakoff, H. H. (1966). The normal personality in our culture and the Nobel Prize complex. In R. M. Loewenstein, L. M. Newman, M. Schur, & A. J. Solint (Eds.), *Psychoanalysis—A General psychology* (pp. 222–252). New York, NY: International Universities Press.

Trzesniewski, K. H., Donnellan, M. B., & Robins, R. W. (2008). Do today's young people really think they are so extraordinary? An examination of secular trends in narcissism and self-enhancement. *Psychological Science*, *19*, 181–188.

Twenge, J. M., Campbell, W. K., & Gentile, B. (2012). Increases in individualistic words and phrases in American books, 1960–2008. *PLoS ONE*, *7*, e40181.

Twenge, J. M., Konrath, S., Foster, J. D., Campbell, W. K., & Bushman, B. J. (2008). Egos inflating over time: A cross-temporal meta-analysis of the Narcissistic Personality Inventory. *Journal of Personality*, *76*, 875–902.

Tyrka, A. R., Wyche, M. C., Kelly, M. M., Price, L. H., & Carpenter, L. L. (2009). Childhood maltreatment and adult personality disorder symptoms: Influence of maltreatment type. *Psychiatry Research*, *165*(3), 281–287.

Ursano, R. J., Bell, C., Eth, S., Friedman, M., Norwood, A., Pfefferbaum, B., . . . Yager, J. (2004). Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. *American Journal of Psychiatry*, *161*(11), 3–31.

Van der Hart, O., Groenendijk, M., Gonzalez, A., Mosquera, D., & Solomon, R. (2013). Dissociation of the personality and EMDR therapy in complex trauma-related disorders: Applications of the stabilization phase. *Journal of EMDR Practice and research*, *7*(2), 81–94.

Van der Hart, O., Nijenhuis, E., & Steel, K. (2006). *The haunted self. Structural dissociation and the treatment of chronic traumatization*. New York, NY: Norton.

Van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: Treatment effects and long-term maintenance. *Journal of Clinical Psychiatry*, *68*(1), 37–46.

Volkan, V. D. (1973). Transitional fantasies in the analysis of a narcissistic personality. *Journal of the American Psychoanalytic Association*, *21*, 351–376.

Winnicott, D. W. (1965). Ego distortion in terms of true and false self. In *The maturational processes and the facilitating environment* (pp. 37–55). New York, NY: International Universities Press.

Yen, S., Shea, T., Battle, C. L., Johnson, D. M., Zlotnick, C., Dolan-Sewell, R., . . . McGlashan, T. H. (2002). Traumatic exposure and posttraumatic stress disorder in borderline, schizotypal, avoidant, and obsessive-compulsive personality disorders: Findings from the collaborative longitudinal personality disorders study. *Journal of Nervous and Mental Disease, 190*(8), 510–518.

Zanarini, M. C., Frankenburg, F. R., Reich, D. B., Marino, M. F., Lewis, R. E., Williams, A. A., & Khera, G. S. (2000). Biparental failure in the childhood experiences of borderline patients. *Journal of Personality Disorders, 14*(3), 264–273.

Zanarini, M. C., Gunderson, J. G., Marino, M. F., Schwartz, E. O., & Frankenburg, F. R. (1989). Childhood experiences of borderline patients. *Comprehensive Psychiatry, 30*(1), 18–25.

Zanarini, M. C., Williams, A. A., Lewis, R. E., Reich, R. B., Vera, S. C., Marino, M. F., . . . Frankenburg, F. R. (1997). Reported pathological childhood experiences associated with the development of borderline personality disorder. *American Journal of Psychiatry, 154*(8), 1101–1106.

Zanarini, M. C., Yong, L., Frankenburg, F. R., Hennen, J., Reich, D. B., Marino, M. F., & Vujanovik, A. A. (2002). Severity of reported childhood sexual abuse and its relationship to severity of borderline psychopathology and psychosocial impairment among borderline inpatients. *Journal of Nervous and Mental Disease, 190*(6), 381–387.

Correspondence regarding this article should be directed to Dolores Mosquera, INTRA-TP, Instituto para el estudio del Trauma y los Trastornos de la Personalidad, General Sanjurjo 111, 5°, 15006, A Coruña, Spain. E-mail: doloresmosquera@gmail.com