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NARCISSISTIC PERSONALITY DISORDER, MALIGNANT NARCISSISM, AND ANTISOCIAL PERSONALITY DISORDER – THE LIMITS OF THE EFFECTIVENESS OF PSYCHODYNAMIC PSYCHOTHERAPY

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psychodynamic psychotherapy
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Summary

The aim of this paper is to discuss selected theoretical concepts of narcissism, with particular emphasis on its subtypes, the characteristics of narcissistic pathology, and the possibilities and limitations of psychotherapy when working with this group of patients. Special attention is given to the distinctions between narcissism and borderline personality organization, as well as the complexity of malignant narcissism, which often marks the boundary of therapeutic effectiveness. The article employs a qualitative approach, combining theoretical analysis from the field of psychodynamic psychotherapy with a clinical case study, allowing for an in-depth reflection on diagnostic and therapeutic challenges. The findings indicate that, in work with individuals exhibiting narcissistic and antisocial personality structures, the primary therapeutic goal is not full personality reconstruction, but rather harm reduction and improvement of daily functioning. Supportive interventions may help mitigate destructive behavioral patterns, although they do not lead to deep structural change.

Narcissism is a multidimensional phenomenon that has been the subject of interest among psychoanalysts, psychotherapists, and clinicians from related disciplines for decades. In the scientific literature various definitions and interpretations of narcissism coexist, ranging from the traditional psychoanalytic concept of narcissism as a libidinal investment of the ego to contemporary understandings framing it as a mechanism for regulating self-esteem. Clinically, narcissism is viewed as existing along a continuum between a normal psychological process and pathology, encompassing various levels of severity and manifestations.

Otto Kernberg developed a detailed classification of narcissism, highlighting its key aspects such as self-esteem regulation, internal object representations, the role of the superego, and defensive mechanisms. He distinguished between normal infantile narcissism, normal adult narcissism, and pathological narcissism, the latter including its most

complex form—malignant narcissism. His work, grounded in a profound understanding of personality pathology, sheds light on the functioning mechanisms of narcissistic patients and the therapeutic challenges they pose for clinicians.

The aim of this article is to discuss selected concepts related to narcissism, including its classification, the core features of narcissistic pathology, and potential therapeutic approaches. Particular attention is given to the distinctions between narcissism and borderline personality organization, as well as to the specificity of malignant narcissism, which, due to its complex mechanisms, represents the boundary of psychotherapeutic effectiveness. This paper also seeks to underscore the importance of differential diagnosis and the potential risks involved in working with narcissistic patients.

A psychodynamic perspective on narcissism – theoretical framework

Narcissism, as a dimension of personality, has long been the focus of extensive theoretical and clinical investigation within the psychodynamic approach. In its classical formulation, derived from traditional psychoanalysis, it is defined as a libidinal investment of the ego. This concept suggests that instinctual energy is directed toward the ego, providing it with internal reinforcement and integration [1]. Contemporary conceptualizations of narcissism extend beyond these boundaries, defining it as a mechanism for regulating self-esteem and self-respect, which can manifest in both normal and pathological forms.

Self-esteem regulation, a key aspect of narcissism, depends on complex interactions between psychic structures. According to Kernberg's theory [2, 3], the superego – through its demands for perfection and its prohibitive injunctions originating in childhood – exerts a significant influence on the ego, potentially leading to a diminished sense of self-worth. When object representations are libidinally invested, the ego receives support through positive images of others who are loved and from whom the individual feels loved in return. However, conflicts related to aggression can weaken this investment, affecting object representations and self-love, ultimately resulting in destabilization of self-esteem.

Kernberg [3] proposed a distinction between three types of narcissism: normal infantile narcissism, normal adult narcissism, and pathological narcissism. Normal infantile narcissism plays a crucial role in personality development, as fixation at, or regression to, mechanisms characteristic of this developmental stage may lead to character pathology. Infantile narcissism involves the regulation of self-esteem through age-appropriate gratifications, including childhood "value systems," which are often associated with demands or prohibitions [4]. In contrast, normal adult narcissism is characterized by a stable ego structure, well-integrated object representations, a mature superego, and the capacity to satisfy instinctual needs within the context of enduring object relationships. At this level, self-esteem regulation remains healthy and stable.

In cases of narcissistic pathology, Kernberg highlights the possibility of fixation at the level of infantile narcissism or regression to this stage. Such pathology often manifests as an excessive dependence on infantile gratifications, which hampers adaptation in adulthood. The most severe form of pathology is narcissistic personality disorder, which can vary in

intensity – from mild difficulties in interpersonal relationships to profound disturbances in identity and functioning.

Table 1. **Severity levels of narcissistic personality disorder**

level 1	Patients who outwardly present as "neurotic" and generally function effectively, but often experience significant difficulties in maintaining long-term intimate relationships and stable, sustained professional or work-related interactions.
level 2	The full spectrum of typical clinical manifestations of this syndrome. In such cases, the personality disorder requires decisive therapeutic intervention.
level 3	Patients functioning at a clear borderline level. In addition to the characteristic symptoms of narcissistic personality disorder, these individuals exhibit marked intolerance of anxiety, difficulties in impulse control, and significant limitations in sublimatory functions – that is, the capacity to engage in productive or creative activities beyond the gratification of basic needs. In clinical practice, these patients are often observed to have prolonged or severe incapacity for occupational functioning and difficulties in establishing and maintaining intimate romantic relationships. A subgroup of patients at this same level of severity does not display typical borderline features but exhibits pronounced antisocial behaviors. From a prognostic perspective, such individuals are classified in the same category as patients at the borderline level due to a comparable degree of therapeutic difficulty and social functioning impairment.

Source: authors' own elaboration based on Kernberg [3]

Patients in the last group (level 3) may respond to psychodynamic psychotherapy focused on transference; however, for individual reasons, such an approach may be contraindicated. In these cases, supportive interventions would be more appropriate.

Narcissistic Personality Disorder (NPD) is characterized by a broad spectrum of pathological features that involve the structure of the ego, interpersonal relationships, superego functioning, and the experience of affective states.

Patients with NPD exhibit excessive egocentrism and a strong dependence on admiration from others. Their self-concept is often dominated by fantasies of success, grandiosity, and uniqueness. At the same time, they avoid confronting facts that could undermine their idealized self-representations, as such confrontations destabilize their sense of self-worth. Episodes of insecurity regarding their self-image further disrupt their conviction of uniqueness and greatness.

The interpersonal relationships of patients with NPD are marked by significant pathology. They often experience both conscious and unconscious envy toward others, and their interactions with their environment are dominated by a desire to exploit others and a sense of entitlement. They frequently devalue other people, while simultaneously demonstrating an inability to develop authentic dependence on them. Their need for admiration, combined with emotional shallowness, lack of empathy, and difficulty engaging in relationships or shared goals, significantly limits their capacity to build enduring bonds.

Superego pathology in patients with NPD manifests at varying levels of severity. At milder levels, deficits in the capacity to experience sadness and mourning can be observed. In such individuals, self-esteem regulation is more closely linked to mood fluctuations than to internalized, self-critical processes. The superego of patients with

NPD is often shaped by a "shame" culture rather than a "guilt" culture, and their value system tends to be childish and unstable. In more advanced cases, superego pathology is expressed in chronic antisocial behaviors, irresponsibility, and an inability to experience guilt for actions that devalue others. A particularly notable phenomenon in this context is malignant narcissism, which combines narcissistic features with antisocial behaviors, egosyntonic aggression, and paranoid tendencies.

Chronic feelings of emptiness and boredom represent one of the most characteristic features of patients with NPD. This state constitutes a core element of their inner experience of the self, leading to an intense craving for stimulation. As a result, these patients often engage in artificial attempts to provoke affective responses, which increases the risk of substance abuse and addictions [5].

Core challenges in the treatment of narcissistic patients

The treatment of patients with narcissistic disorders involves numerous challenges arising from their characteristic defensive mechanisms and specific personality traits. A primary difficulty is their inability to accept dependence on the therapist, which they perceive as a form of humiliation. In response to this challenge, they often attempt to engage in self-analysis, which hinders the development of an authentic therapeutic relationship. Another characteristic feature of narcissistic patients is their competitive attitude toward the therapist, accompanied by the suspicion that the therapist is motivated solely by indifference or self-interest. They are unable to believe that the therapist could be spontaneously interested in them or genuinely concerned about their well-being [6]. This dynamic fosters defensive idealization of the therapist, coupled with both conscious and unconscious envy regarding the therapist's creativity, competence, and ability to form relationships. Patients with NPD tend to create a dynamic in which "there can only be one great person" in the therapeutic setting. They devalue the therapist in order to maintain their sense of superiority and significance. One of the most destructive elements of this dynamic involves negative countertransference reactions and conflicts triggered by envy. In such situations, the patient often feels inferior, especially when required to acknowledge that the therapist has been helpful. An additional challenge involves chronic suicidal tendencies, which, in narcissistic patients, often have a calculated and coldly sadistic character, distinguishing them from the impulsive suicidal behaviors typically observed in patients with borderline personality disorder [7].

The crucial role of differential diagnosis in identifying borderline, narcissistic, and antisocial personality disorders

Kernberg provides a detailed analysis of the differences between narcissistic personality structure and borderline personality organization, highlighting key distinctions in the psychological functioning of patients experiencing these disorders. According to his conceptualization, the narcissistic structure is characterized by "an integrated, albeit highly pathological, grandiose self" [8]. In pathological narcissism, fragmented and impoverished

self-representations are organized around this grandiose self, which serves as a defensive mechanism. This organization allows the patient to avoid identity diffusion and the weakening of psychic functions that are characteristic of borderline personality [8].

In one of his articles devoted to working with nearly untreatable narcissistic patients, Kernberg [9] emphasizes the particular difficulty posed by malignant narcissism. He considers it one of the greatest challenges in psychotherapy, marking the boundary of therapeutic possibilities. Kernberg underscores that therapists are exposed to significant risks in relationships with narcissistic patients, including conflicts, potential personal harm, and the danger of being drawn into sadomasochistic relational dynamics. Working with such patients also involves the discomfort of confronting sadistic fantasies that may emerge during the therapeutic process. These factors pose a serious challenge to the therapist's sense of safety, which is a crucial condition for effective therapy with this group of patients. The intensification of aggressive-paranoid behaviors often limits the potential for psychoanalytic therapeutic interventions. Paradoxically, however, the very behaviors that reinforce the patients' sense of power and uniqueness may prove useful in transference interpretations. For instance, suicidal or parasuicidal behaviors are sometimes expressions of triumphant aggression directed at family members, the therapist, or the world for failing to meet their expectations.

Kernberg [9] emphasizes that a key aspect of therapy lies in distinguishing between malignant narcissism, which may be amenable to treatment, and antisocial personality disorder, which remains beyond the reach of contemporary therapeutic methods. Understanding these differences is fundamental for the effective selection of therapeutic strategies and minimizing the risk of treatment failure. The author describes malignant narcissism as a pathological form that combines features of narcissistic personality disorder with antisocial behaviors, heightened paranoid tendencies, and egosyntonic aggression directed both toward the self and others. He characterizes this group of patients as displaying arrogance, extreme egocentrism, and a lack of empathy and concern for others, while simultaneously demonstrating a strong need for admiration and approval. These behaviors are further reinforced by a tendency toward contempt and exploitation of others, as well as pervasive, intense envy. Such individuals often experience a chronic sense of boredom, which limits their capacity to derive lasting satisfaction from life. Their inner world is impoverished in "good objects," that is, representations of supportive and satisfying relationships, leading to the predominance of idealized self-images. Kernberg [10] underscores that an inability to experience sadness, longing, and depression is a core feature of their personality. Their strong conviction of their own greatness and perfection allows them to avoid acknowledging their dependence on other people. He describes individuals suffering from narcissistic personality disorder as "orally fixated," referring to their voracious and unbalanced hunger for both psychological and material resources. Kernberg also notes structural similarities between pathological narcissism and borderline personality organization. Both disorders are characterized by reliance on primitive defense mechanisms, such as splitting, denial, projective identification, omnipotence, and primitive idealization. Moreover, patients with narcissistic and borderline traits tend to initiate conflicts, which are often fueled by intense aggression expressed in communication. Their psychic life is devoid of sustaining relationships, and their inner reality is dominated by idealized self-representations. People in the

narcissist's environment are treated instrumentally, merely as means to achieve their own goals, and those who fail to meet their expectations are perceived as threats. At the core of these patients' functioning lies an image of an enraged, empty self, filled with anger and helplessness, reflecting their deep-seated fear of a world they perceive as hateful and vindictive – much like themselves [8].

Yeomans [11] provides a detailed analysis of the differences between malignant narcissism and antisocial personality disorder, highlighting key aspects that distinguish these two conditions. He emphasizes that "sociopaths and psychopaths" (individuals with antisocial personality disorder) display complete indifference toward others, meaning they have no need to establish relationships. In contrast, a person diagnosed with malignant narcissism, despite the destructive features of their personality, retains a certain need to connect with others, although they believe that unless they "inflate" their grandiose self, they have nothing of value to offer. One of the crucial elements in understanding malignant narcissism is the conflict between the desire for contact with others and aggressive impulses directed toward them. This very conflict offers hope for the effectiveness of therapy, as it indicates the presence of internal tension with which the patient struggles in interpersonal relationships. In sociopathy, by contrast, no such conflicts are present; the instrumental treatment of others serves solely to satisfy personal needs and pleasures, without any sense of ambivalence.

In his work with narcissistic patients, Yeomans draws attention to the specific dynamics of transference and countertransference. Individuals with malignant narcissism often appear as if they are completely isolated from the therapist, creating an experience of absent transference. These patients function in solitude, and their emotional isolation may evoke in the therapist a sense of being invisible to them, which significantly complicates the therapeutic process. Countertransference presents a major challenge in such cases. Yeomans underscores the importance of distinguishing between the therapist's own feelings arising from their personal experiences and those provoked by the patient. He cites the example of a female patient who, during a telephone session, accused her therapist of being a "monster" after the sound of an opening window triggered fear in her. This experience elicited in the therapist a profound sense of guilt and the conviction that he was indeed insensitive to the needs of others. This example illustrates how patients with malignant narcissism can transfer their internal conflicts onto the therapist, inducing a state of intense emotional reaction.

Clinical example: diagnostic challenges – malignant narcissism or antisocial personality disorder

Context of referral and first impressions: The patient, a 40-year-old man, was referred to a psychologist/psychotherapist by a social welfare center due to low mood resulting from a difficult financial situation. At the time of referral, he had been unemployed for several months, was not in a relationship, and lived alone in a city-provided apartment. He had never been married and had no children. His income consisted of social welfare support, assistance from his parents, and occasional jobs, which he would quickly abandon or lose due to episodes of anger. The money he obtained was spent mainly on immediate needs,

such as muscle growth supplements or tanning salon visits. He did not consume alcohol but used other psychoactive substances that could not be clearly identified (so-called "legal highs"). He had completed vocational education. The only long-term activity he had engaged in over the past few years was bodybuilding, albeit at an amateur level. The patient exercised frequently at the gym and took protein supplements, which resulted in a very muscular physique that could be perceived as intimidating.

The patient began weekly therapy at a public facility, expressing a desire to improve his mood and life situation. The therapeutic goals were established as finding stable employment and managing anger (resisting aggressive impulses and refraining from immediate reactions).

During the initial sessions, the man presented with a dominant and loud demeanor, quickly taking the initiative in conversations and describing his situation in a dramatic manner, which evoked unease and a sense of rivalry in the therapist. He complained of low mood, anxiety, financial difficulties, and family conflicts. His relationships with others appeared very superficial, and people who failed to meet his expectations were devalued. His contacts with his parents were limited to instrumental use of their support. Biographical data revealed numerous legal issues (assaults, fraud), difficulties in family relationships, and the absence of any long-term partnerships. The patient demonstrated a lack of insight into his behavior, attributing the causes of his situation to external factors and other people. His declared sadness and anxiety were not reflected in his demeanor – he appeared confident, often cheerful, and amused.

Based on personality traits such as grandiosity, exaggeration of abilities and achievements, arrogance, haughtiness, lack of empathy, and a sense of entitlement to exploit and abuse others, the patient was diagnosed with Narcissistic Personality Disorder (F60.81 [301.81]). From the outset, there was also a suspicion of Antisocial Personality Disorder (F60.2 [301.7]), due to behaviors such as property destruction, violation of social norms, aggression toward others, lying and deceit, instigating fights, assaults on others without premeditation, failure to repay debts, and inability to maintain steady employment.

Psychodynamic diagnosis: The patient exhibited identity diffusion, manifested in an unintegrated representation of the self and significant others. His relationships were polarized – he perceived others as either idealized or entirely bad, depending on whether they fulfilled his needs. His self-image was inconsistent, and his behavior was chaotic, leading to difficulties in employment and in forming mature intimate relationships. The patient's defensive mechanisms were based on splitting, devaluation, and regression. He retained the capacity for reality testing, although he experienced difficulties in understanding the principles of social coexistence. His object relations were oriented exclusively toward the gratification of his own needs, without reciprocity, and his moral functioning was marked by significant deficits, including a lack of guilt and shame. He displayed intense aggression toward others, involving both verbal and physical violence. Furthermore, the patient struggled to integrate loving feelings with sexual behavior, which deepened his emotional isolation.

Qualification: Based on Otto Kernberg's classification of personality pathology, it was determined that the patient exhibited a low level of borderline personality organization with strong narcissistic features and possibly antisocial traits. The man demonstrated poor

mentalization capacity, difficulties in maintaining a genuine therapeutic relationship, and functioned at a low intellectual level. The dominant self-object representation dyad was as follows: a strong, omnipotent, and cruel self in relation to a weak, frightened object. This dyad shifted multiple times during sessions, in which the therapist was perceived as strong and cruel. At the beginning of treatment, psychodynamic expressive psychotherapy was proposed; however, after several months, it was replaced with psychodynamically oriented supportive therapy (POST) of unspecified duration. The frequency of sessions was set at once per week.

Therapy history: During the first months of work with the patient, sessions were characterized by high tension and a sense of ongoing struggle. The patient appeared overly stimulated, dominant, and seemed on the verge of an outburst. He appeared to control the course of the sessions, which was interpreted as a manifestation of omnipotent control stemming from his fear of criticism. He frequently reversed roles within the therapeutic relationship, presenting himself as strong and dominant while assigning the therapist the role of weak and insecure.

After several weeks, the atmosphere of the sessions began to shift—the patient appeared more relaxed, and the therapeutic relationship became less tense. Elements of idealization combined with devaluation of the therapist emerged, which was interpreted as the result of paranoid-narcissistic transference. The patient began speaking more chaotically about his life, with narratives that were extremely distorted – alternating between idealization and devaluation. In subsequent sessions, he projected primitive emotions such as envy and anger onto the therapist, leading the therapist to identify with these feelings. The therapist experienced intense emotions, including pity, contempt, and even boredom, which interfered with maintaining focus and engagement in the therapy. The patient, on the other hand, appeared satisfied with the sessions, treating them as a space for dominance and imposing his own narratives. Through supervision, the therapist realized that the patient had taken control of the therapeutic process, employing intimidation and devaluation as strategies. The therapist also recognized the need to obtain collateral information from external sources, which, according to Kernberg's conceptualization, can be a key component in working with patients who exhibit such traits.

Between the third and sixth month of therapy, the patient continued to exhibit difficulties in cooperation, which took the form of manipulation (he attempted to convince the therapist of his willingness to work on himself and expressed affection toward him, while outside the therapy room he described the sessions as a waste of time and admitted to "playing the therapist for a fool"), devaluation (increasingly mocking the therapist's comments, claiming they were completely off-base: "what you're saying is garbage," "what kind of nonsense is this?"), and both overt and covert aggression (he described incidents such as breaking off a car mirror or scratching the cars of people he considered hostile, adding that he knew what vehicles "everyone here" drove). Although he agreed to the therapist consulting with other institutional staff members, the information he provided was inconsistent and inaccurate. Attempts to confront him about his lies triggered intense defensive reactions, including sudden devaluation of the therapist. During sessions, the patient often avoided reflection, adopted an arrogant stance, and was openly aggressive (raising his voice to the point of shouting and using vulgar language). His

conversations were dominated by extreme devaluation of third parties and a marked lack of self-criticism. Phenomena described by Bion [12] as the "arrogance syndrome" were also observed, including aggression, lack of reflection, and a curiosity focused on the weaknesses of others rather than on introspection. At one point, the patient accused the therapist of conspiring to deprive him of financial resources, which escalated into verbal aggression and threats ("I know what you drive," "I know what car you have," "you're already dead," "I'll destroy you"). The conflict ended with the patient terminating therapy on his own initiative, while simultaneously filing complaints about the therapist with the institution's management. The therapist considered it unjustified to continue therapy under such circumstances; however, the formal requirements of the public institution obliged him to resume treatment if the patient chose to return. After some time, the patient reappeared for sessions, expressing remorse and gratitude, although his apologies seemed devoid of authentic guilt. His return appeared to be motivated by a desire to obtain specific benefits, without any intention to reflect on his prior behavior. This pattern recurred several times, indicating the patient's difficulties in building a stable and authentic therapeutic relationship.

In the final phase of therapy (months 6–8), the therapist increasingly questioned the effectiveness of the intervention. The patient exhibited a limited capacity for reflection. His pervasive contempt for others – and often for the therapy itself—significantly hindered analytic work. Consequently, the therapist decided to implement elements of psychodynamically oriented supportive therapy (POST). First, sessions became more structured, and the therapist adopted a more directive stance: guiding the conversation, avoiding transference analysis, and introducing clear rules for cooperation (e.g., shouting was not permitted). The therapist worked to strengthen the patient's ego by helping him curb impulsivity, highlighting the potential consequences of specific behaviors, and reinforcing moments when his behavior facilitated positive interactions. Psychoeducation and social modeling were introduced to teach socially acceptable behaviors, including tension reduction strategies (e.g., counting, breathing techniques, deliberate delay of reactions). The therapist also engaged the patient in analyzing the process of seeking employment.

As a result of setting clear boundaries and avoiding transference analysis, the patient demonstrated the greatest degree of improvement. Sessions became less chaotic and more focused on concrete goals. Breathing techniques and deliberate response delay produced observable progress in impulse control. The man reacted less aggressively and more often attempted to inhibit immediate outbursts. Focusing on analyzing his behavior in relationships and its consequences elicited greater openness on his part. He appeared willing to learn social strategies that might bring him tangible benefits, though no deeper changes in his personality structure occurred. By the end of the sessions, the patient was functioning somewhat better and provoking fewer conflicts. In the eighth month of therapy, he accepted a job offer as a security guard and terminated therapy with a terse and demeaning remark: "I'm getting the hell out of this shithole."

Differential diagnosis: malignant narcissism versus antisocial personality disorder

Malignant narcissism and antisocial personality disorder share many similarities, particularly regarding a lack of empathy, aggression, and the instrumental use of others (the therapist, during treatment, is exposed to risks both in the psychological and real-world domains [9]), making their differentiation highly challenging. A key distinction lies in the presence of internal conflict, which is observed exclusively in individuals suffering from malignant narcissism. After achieving a sense of well-being (often at the expense of others), they exhibit a need to establish connections with those around them. In contrast, individuals with antisocial personality disorder have no need for close relationships; other people are merely "tools" for achieving specific goals. Furthermore, such patients show no signs of internal conflict concerning their self-worth – they do not seek recognition but instead strive for domination and control [11]. The absence of any inner conflict leaves little hope for meaningful internal change through therapy in these individuals.

Following the termination of treatment with the patient described above, the therapist revised the initial diagnosis. He concluded that the patient suffered from antisocial personality disorder, based on features such as a pathological grandiose self deeply infused with aggression, states of arrogance, superiority, and contemptuous attitudes toward the therapist, and, most notably, a consistent lack of conflict regarding any desire for close relationships or even recognition from others.

Psychodynamically oriented supportive therapy (POST) appeared to be a far more appropriate approach than transference-focused psychotherapy (TFP). However, given the patient's profound difficulties in forming a therapeutic alliance, a combination of psychoeducation and cognitive-behavioral techniques might have been more effective. Nevertheless, it is important to recognize that such patients may exploit "psychological techniques" for their own advantage.

Conclusions

Narcissism, as a multidimensional psychological phenomenon, has been extensively studied within the psychodynamic framework, which considers both its structural and functional aspects. Pathological narcissism, particularly in its malignant form, is characterized by profound deficits in ego functioning, object relations, and the superego. Individuals with this disorder exhibit intense defensive mechanisms such as splitting, devaluation, and projective identification, which hinder the formation of authentic relationships and effective participation in therapy. Their inner world is filled with idealized self-images, while their relationships with others remain instrumental and devoid of reciprocity.

Therapeutic work with patients exhibiting malignant narcissism or antisocial personality disorder places exceptionally high demands on clinicians. These disorders, located at the borderline of psychotherapeutic possibilities, often demonstrate limited responsiveness to treatment. Such patients rarely possess the capacity for deep reflection, and their intense hostility and tendency to devalue the therapeutic relationship complicate the therapeutic process.

The case presented in this article illustrates these challenges particularly vividly. Although the patient sought therapy, he did not demonstrate an ability for authentic reflection on his own behavior, and his approach to the therapeutic relationship was primarily instrumental. In the initial phase of treatment, his defensive mechanisms of devaluation and aggression significantly complicated the therapeutic process. His tendency toward confrontation and need for dominance rendered classical psychodynamic analytic approaches ineffective.

The implementation of psychodynamically oriented supportive therapy (POST) made it possible to reduce destructive behaviors and create a minimal space for working on more adaptive functioning strategies. Key interventions included structuring sessions and introducing clear rules of engagement, which gradually reduced the patient's impulsivity and his tendency to escalate tension in interactions with the therapist. Tension-reduction techniques, such as breath control and deliberate delay of reactions, proved particularly effective and contributed to modest improvements in emotional regulation.

Despite these supportive interventions, the patient showed no signs of deeper structural personality change, and his functioning within the therapeutic relationship continued to be marked by an instrumental attitude toward the therapist. His decision to terminate therapy also reflected this pattern – he did not perceive it as a reflective process but rather as a phase in his life that ceased to be useful once immediate benefits had been obtained.

This case confirms that, in working with individuals with antisocial personality structure, the primary goal is not personality reconstruction but rather harm reduction and enhancement of their day-to-day functioning. Supportive interventions can help to mitigate destructive behavior patterns to some extent but do not lead to profound structural change. In the case described, it was possible to achieve a limited improvement in the patient's adaptive skills in social and occupational contexts; however, his fundamental relational patterns and emotional regulation strategies remained unchanged.

This therapeutic narrative also raises important questions about the advisability of continuing therapy within institutional settings when a patient repeatedly interrupts the process and treats it instrumentally. Instead of obliging the therapist to persist in such engagements, it may be more appropriate to establish institutional boundaries that prevent the patient from repeatedly exploiting therapy as a tool for obtaining immediate benefits without genuine readiness to work on themselves.

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