Working with narcissism in psychotherapy with people with dementia

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Dementia

Dementia is an umbrella term used to describe a group of illnesses that reduce the ability of the brain to function. The most common of these illnesses is Alzheimer's Disease, which, in the initial stages, is characterised by difficulties in establishing new, verbal memories, and by a gradual loss of fluency. However, the clinical signs and symptoms experienced by people with dementia vary widely: memory and perceptual impairments are characteristic of vascular dementia, while visual hallucinations, fluctuating cognition and movement problems are common in dementia with Lewy bodies. Nevertheless, regardless of the exact presentation of symptoms, all forms of dementia are characterised by common factors: the illness is progressive, so that it gradually affects all areas of cognitive and behavioural functioning, and, at present, it is incurable.

In the UK, recent estimates suggest there are between 670,000 and 800,000 people living with dementia (Matthews et al, 2013). This figure represents around seven per cent of the population who are aged over 65, and includes about 15,000 people from black or minority ethnic groups. Dementia primarily occurs in those aged over 65, with the incidence of dementia roughly doubling every six to seven years. Thus, while most people who have dementia are older, there were thought to be over 42,000 people with young-onset dementia (under the age of 65 years) in the UK in 2013. Although people with Alzheimer's Disease can be prescribed medications such as Donepezil or Aricept, the impact of these drugs is limited, and while they may slow the rate at which people decline for a brief period, dementia cannot be cured.

Narcissism in people with dementia

Narcissism is typically referred to as existing on a spectrum or continuum ranging from people who display a few narcissistic traits, to others who would meet the diagnostic criteria for a Narcissistic Personality Disorder (McBride, 2008). Narcissists oscillate between states of high, often, grandiose levels of outward or explicit self-esteem, and fragile states of shame, anguished depression, and dysregulated affect in which their interior or implicit self that is experienced as empty (Horowitz, 1989; Young & Flanagan, 1998; Dimaggio et al., 2002). Consequently, narcissists have a need for admiration or validation as well as a deep sense of entitlement, even though their achievements do not merit this. At the same time, however, narcissists are unable to deal with criticism, and their own hidden feelings of insecurity and shame are projected into others. Consequently, narcissists are themselves highly critical of others, and attacking of those who challenge or undermine their external self.

The causes of narcissism are likely to be complex with multiple components (Paris, 2014), but has been associated with parenting styles that both overemphasize the child's specialness and yet also involve excessive criticism with fears and failures being harshly responded to (Symington, 1993). During their childhood, a narcissist learns to see themselves and the world through a dual lens: both that they are special and also that failure is intolerable. To experience failure or to acknowledge a fall from the special position risks being experienced as profoundly shameful–in which the self is threatened by feelings of worthlessness, failure, rejection and vulnerability. Consequently, the narcissistic child may hide their low self-esteem by developing a superficial sense of perfection and behaviour that shows a need for constant admiration – this is a false self (Modell, 1975).

Narcissists often struggle to recognise or to understand other people's emotions, and as well as disdaining those people that they feel are inferior to them, they typically have little compunction in abusing or exploiting any positions of power that appear (Kernberg, 1975). The relationship between the narcissist and those who are close to them, therefore, is often complex, as the narcissist's behaviour forces others into a position whereby they either allow themselves to be crushed and dominated or they rebel in order to regain some control. When a narcissist feels that their importance has been brought into question, then such insults to the self may lead to narcissistic rage. For Kohut (1972), narcissistic rage is related both to revenge and to the narcissists' need for total control or the world around them, including the wish to restore a sense of safety and to eliminate the threat to their self-esteem. For those around the narcissist, then, much of their behaviour may be motivated by the need to avoid puncturing the fragile bubble of the narcissist's self-esteem, and thus triggering their rage.

Given that a central feature of narcissism concerns the need of an individual to position themselves as perfect, and thus to reject any suggestion of fault or failure, it is not surprising that the association between narcissism and cognitive impairment, including dementia, has recently been explored (e.g. Poletti and Bonuccelli, 2011). In a prospective cohort study of 452 participants, narcissistic vulnerability traits were significantly associated with increased risk of Alzheimer's disease (Serrani, 2015). It has also been suggested that narcissism may influence adaptation to traumatic brain injury, typically being associated with poorer recovery (Barak, 2017). In these instances, brain injury serves as a severe narcissistic insult, which threatens self-worth and triggers distress. In particular, individuals with a history of pre-morbid narcissistic problems may have intensified problems in accepting and coping with the effects of brain injury (Klonoff and Lage, 1991).

Dementia and Psychotherapy

Psychotherapy can often play an important role in helping patients adjust to a broad range of life limiting and life ending illnesses. The emphasis within psychotherapy on helping clients to resolve emotional threats, to take greater control over their lives and to find strategies to "*live well*" means that psychotherapy also potentially has much to offer within dementia care. Given the combination of powerful emotional responses to dementia (Aminzadeh *et al*, 2007) and the desire of most people to know about their illness (Ouimet *et al*, 2004), it is perhaps unsurprising therefore that psychotherapeutic approaches with people affected by dementia are becoming increasingly common. In a recent review of psychotherapy with people with dementia, Ada Ivanecka and I were able to identify 26 papers that had used controlled trials or repeated measured designs (Cheston and Ivanecka, 2016). We found that these papers described a broad mix of therapeutic modalities, lengths and settings, including two studies using psychodynamic interpersonal therapy (Carreira *et al*, 2008; Burns *et al*, 2005). In addition, a number of case studies and other reports of psychodynamic therapy exist (e.g. Sinason, 1992; Davenhill, 2007; Balfour, 2014)

At the same time, however, there are many challenges to adapting psychotherapy for this client group: not only is there the impact of the neurological impairment, but the emotional weight of a diagnosis and the residual social difficulties in talking about dementia can all make it difficult for clinicians to find ways to engage meaningfully with people affected by dementia. These barriers are likely to be further exacerbated by the lack of specialist support provided to people after they have received a diagnosis (Watts *et al*, 2014). The reality, then, is that while the role of psychotherapy is increasingly recognised, most people who are diagnosed with dementia will not be routinely offered access to any form of counselling, let alone psychodynamic therapy.

Threat, dementia and psychotherapy

Dementia represents a significant, potential threat to self not only because it is an incurable illness that involves a progressive decline ending ultimately in death, but also because it is characterised by increasing dependency, the potential loss of identity and challenges to meaning and purpose. For these reasons, worries about developing dementia are one of the most significant fears of growing old (Kessler *et al*, 2012). A potential role for psychotherapy with people with dementia, then, is to help people to engage with their experiences of dementia - and in particular with the psychological threat that dementia represents. For many people, the initial task is to find a way of putting a form of words to their experiences (Shotter and Gergen, 1989). One aspect of this use of language to frame their experiences comes in the use of terms such as "*dementia*" or "*Alzheimer's Disease*" (Cheston, 2013). While ostensibly this is a simple task, in practice it is often much harder. For instance, one study of awareness in people with dementia found that over a third of the 64 participants did not use a diagnostic label to refer to their symptoms (Clare *et al*, 2016

One way to think of this is to draw a parallel with the way in which, many of the characters in JK Rowling's Harry Potter stories are too terrified of Lord Voldemort, the central villain, to refer to him directly and instead resort to euphemisms such as "*he-who-must-not-be-named*" or "*the Dark Lord*". Elsewhere I have argued that one reason for this reluctance to put a name or label to the illness of dementia arises from a fear that to do so will lead to a loss of internal control (Cheston, 2015). Many people with dementia describe facing just such a dilemma: either to engage with the emotional threat of dementia (and risk an escalation of their distress), or to avoid exploring those experiences (and risk the loss of control that arises from pushing away such knowledge). Within psychotherapy, expressions of this choice have been referred to as markers of a "*fear-of-loss-of-control*" (Honos-Webb, Lani and Stiles, 1999; Honos-Webb, Surko and Stiles, 1998). Amongst the different fears that further expression of the problematic material may lead to are fears of going mad, being excluded or rejected or being defeated. All of these concerns relate, fundamentally, to a fear of loss of control. For people with dementia, then, beginning to explore and put a name to their illness can be problematic. As one man in a psychotherapy group explained:

Mr B: I find I've, I've got a great deal of moral uplift by coming here
    Meeting you, listening to the way you do it
  And I don't see the problem now
    it frightened me, the problem of declining memory,
    until I came here
    and now I'm not frightened
    (...)
  It frightened me

> *because I thought, well, I'm going mad, I'm going crazy*
> What am I going to be like in another five years?
> But now I realize that everybody is getting this problem
> (quoted in Watkins et al, 2006)

The way in which this existential threat is experienced by people who are living with dementia is likely to differ. For narcissists, the increasing difficulties in carrying out the many different tasks that are part and parcel of everyday living, may present specific challenges. In particular, these changes may be experienced in terms of a loss of control over not only their cognitive functioning, but also in terms of a changing relationship with the social world. To admit to no longer being able to carry out simple tasks because of the diminishment of dementia, is likely to be intolerable because such failures threaten the narcissist's heightened sense of their own self-worth. Similarly, even to acknowledge the diagnosis of dementia would threaten the fragile nature of their self-concept. I will now look at a case example of working with a woman with strong narcissistic tendencies, to illustrate the potential impact of marital psychotherapy in easing adjustment and enhancing resilience.

Anna King: the need to be right even when you're wrong.

Anna King was a 78-year old retired medical secretary when she was referred to the memory clinic. She had four children and five grandchildren and it had been her family who had persuaded her that she first talk to her GP about her memory difficulties. Anna had suffered a small stroke ten years before she was referred, but this did not cause significant memory difficulties. Anna's husband and two of her daughters confirmed that they had noticed her becoming more forgetful over the last few years - she could be muddled with facts and could not always recall what they had told her. They felt her problems were exaggerated if she was anxious or outside her usual routine.

After Anna's initial appointment at the memory clinic in September 2013, she was referred for a CT scan. She returned to the memory clinic in November to learn the results of the assessment and was told that the most likely diagnosis was one of Mild Cognitive Impairment, as although there were some cognitive changes, these did not appear to be impacting significantly on her daily activities. Anna's scores on the assessment tool used in our clinic are shown in Table 1.

When Anna returned in 2014 for an annual follow-up appointment, her family emphasised that her cognitive impairments were having more of an impact on her ability to carry out normal daily activities. As her scores on the cognitive assessment tool had also deteriorated, Anna's diagnosis was altered to one of "*memory impairment, probable early Alzheimer's Disease*", and she was offered donepezil. A year later, in September 2015, Anna's cognitive and functional difficulties had remained stable but her doctor at the memory clinic felt that it might be helpful for Anna and Philip, her husband, to work with a psychotherapist and referred her to me. According to the referral letter:

> *"Anna and Philip are both frustrated about her forgetfulness. She has varying levels of insight and sometimes gets stuck on the same thing in a conversation but is anxious about the diagnosis and is finding it hard to accept. Philip admits to having his own difficulties in adjusting to the situation … He finds he now over-reacts when Anna gets muddled and forgetful with things*"

I met Anna and Philip for the first time in October. Anna, herself, did not feel that she needed any help - or at any rate, no more help than any woman of her age, with a large family would need. She joked that her family name was King - King by name and King by nature. Her description of her life positioned her as an independent and self-reliant woman. She told me that "*I know that I can push to the back of my mind things that don't matter or which are irrelevant*". There was also some sense of a slightly self-knowing and self-mocking narcissism when she told me "*I can't be wrong, I have to be right - just like my father … I don't like to be wrong. Ever*!! (with emphasis)" then she caught my eye, winked and laughed. Later, when describing the way in which her adult children had insisted that she come to the memory clinic, she said that they thought she was "*doolally*". Similarly, at the end of our session, when I told her that she could leave her tea cup, she joked that I would think her a terrible woman to make a mess like this and not clear it up. She then apologised for taking my time up and added that she was sure I would go home and tell my wife that a stupid woman had wasted my time today.

I was struck by Anna's difficulties in acknowledging personal weakness and change. Her perceptions of me seemed to be coloured by defensive projections of her own unwanted self-traits onto others. If Philip gently suggested that she had made an error because of her memory, then Anna responded either by blaming him or by dismissing his concerns. Anna's response to her dementia therefore seemed to include a number of what Hotchkiss has described as the seven deadly sins of narcissism. First, she used elements of magical thinking to frame herself as a perfect, whilst projecting the shame of failure into others (Hotchkiss, 2008). Then, when her cognitive impairments were mentioned, she responded by reflating her sense of self-importance and diminishing or minimising Philip. At the same time, other elements of narcissism including arrogance, envy and bullying exploitation seemed to be minimal or absent.

During their childhood, a narcissist learns to see themselves and the world through a dual lens: both that they are special and also that failure is intolerable. To experience failure or to acknowledge a fall from the special position risks being experienced as profoundly shameful – in which the self is threatened by feelings of worthlessness, failure, rejection and vulnerability. So Anna described a farther who was punitive and critical: demanding and egotistical. It was from her father that Anna had learnt the phrases that she so often repeated during our sessions: "*king by name, king by nature*" and "*always right, even when I'm wrong*". For her father, his specialness was a matter of family pride - and Anna critically described how her siblings had deviated from this template of specialness.

At the same time, Anna's childhood involved a struggle with disability. She had been born with one leg significantly shorter than another, and spoke both of courses of treatment in hospital, and of the long time that she had spent wearing a leg brace or calliper. However, she emphasised that unlike her sister, she had never let disability stand in her way - she had always excelled. In this sense, Anna, seems to have hidden her low self-esteem by developing a false self - a superficial sense of perfection and behaviour that also demanded admiration from others and especially from Philip.

A central aspect of narcissism, then, concerns the way in which the person relates to failure. As her Alzheimer's disease progressed, so the neurological impairment inherent in the illness reduced the range of daily activities that Anna could engage in: at first tasks like using the phone, or keeping appointments were compromised; but steadily, skills that were even more fundamental to her well-being, including driving their car or cooking became threatened. Anna responded to the potential narcissistic injury to her self through a multi-layered strategy: first she claimed that she had chosen not to engage in these tasks, because she knew that Philip liked to do them; then she asserted that she still did all the jobs that she wanted to, and that nothing of significance had changed; finally, she rejected any implication from Philip's description of her life that could be taken as suggesting that she experienced problems. Just as

In therapeutic terms my aim was to find a way of helping Anna and Philip to talk together about those changes that had taken place. For Philip, it seemed important to be able to have a conversation with Anna in which she could, at least occasionally, acknowledge his role and her neediness. However, I was unsure whether this would be a useful strategy for Anna, who was engaged in warding off her diagnosis - not only did she insist that there was nothing wrong with her, but she avoided talking about her Alzheimer's disease. In our third session, therefore, I tentatively offered a reformulation to them both: I suggested that both Anna and Philip were being asked to address a painful issue - one of how their life had changed as they grew older. For some people growing old meant having a hip replacement, while for others it meant that their memory was worse. I said that this often led people to be angry with themselves for not being able to do all that they wanted to do, and that sometimes this anger spilled out. One way through this was to be able to forgive oneself for growing old.

The analogy between memory loss and needing a hip operation appealed to Anna - because these changes were more likely with age, even if they were not inevitable. We agreed to meet on a monthly basis to talk about how ageing had affected them both. In talking about how change affects people, so Anna found it helpful to reflect on her parents contrasting approaches to life: while she identified with her father's independent self-reliance, her experiences of her mother were of a more compassionate, and forgiving person. Anna recalled how as a child she had hated the way in which her disability meant that her independence was constricted. It was her mother's compassion and tenderness at this time that touched her now.

The narcissistic defence, then, against failure and its implication of a shameful self of weakness, is to develop a false self of omnipotence. The artificiality of this false self may be experienced as something of a role, played out for public consumption. At times, Anna was able to position herself within a slightly self-knowing, self-mocking persona. If she felt safe within the sessions, for instance when her difficulties around living were constructed in a gentle way that did not directly confront her, then she tended to end discussion by delivering what was clearly something of a familiar catchphrase - "*as you know, darling, I'm always right, even when I'm wrong*".

A year into our work together, Anna reflected that as children, she and her brother and sister had been aware of her father's impossibility - that his determination to insist that he was right, even when he was wrong, was, in effect, more a reflection of his acting than of reality. She said her mother would, come into the kitchen and "*give one of those looks and say 'he's at it again'*". I asked if it was like that with you and Philip, and Anna smiled while Philip gently laughed. This connection opened discussions up in two ways. First, Anna asserted that she would lose herself if she stopped arguing and asked Philip "*what sort of person* *would you prefer - someone who had character, who answered back and did things, or someone who just sat there, doing nothing except watch the TV all day*". In turn, this led Philip to say that *"it would be nice, even just once, if you could admit that you change your mind".*

It also allowed us to think again about Anna's experiences of the memory clinic. She had found the assessment "*embarrassing*". I suggested that other people told me that they found being assessed made them feel stupid - to which Anna agreed that was what she had felt too. Shortly after this, Anna allowed Philip to talk about a Cognitive Stimulation Therapy (CST) group that Anna attended as being for people with Alzheimer's. In response Anna said to me: "*it's a good thing for you, that there's people like me with this condition, otherwise you'd be out of a job*". Later in this session, Anna again repeated the phrase "*with my condition*". When I reminded Philip and Anna of his remark about hoping that she might admit that she changed her mind, Anna then joked that she often said he should buy her a camera, so that she could play it back to him and prove that he was wrong. Philip replied, laughingly, that she would blame him and refuse to accept it. Anna joined in the joke and said that she would say he had bought the wrong camera.

Oscillating ambivalence

Although Anna rarely initiated a discussion about her dementia, and did not use the terms "*Alzheimer's disease*" or "*dementia*" to refer to herself, nevertheless she continued to allow Philip or myself to do so without contradicting us or rejecting these labels. As our work progressed, then, she moved away from consistently rejecting any suggestion that her memory was less than perfect towards a more nuanced position. If her memory and other failures were empathically positioned within a broader context of ageing, then Anna would often allow herself to be framed as having dementia. At these times, she also became more accepting of her difficulties. She asserted that she still did things that she felt were important,, such as cooking, but what she now thought was important had changed, and had become more focussed. Anna said she was able to let things go now in a way that she wouldn’t have done when she was younger. As the sessions progressed, so Anna also acknowledged how she had lost confidence in herself, and found it increasingly difficult to go out. She said she was aware of becoming more introverted and now wanting to stay at home even when Philip encouraged her to go out. During one session, I asked Anna what the worst thing about having Alzheimer’s disease was for her. She told me that it was the thought that she might become stupid, and when I asked her to tell me more about this, she replied that she meant it was being dependent, inactive and being looked after - the horror of not being able to do crosswords and puzzles, or of being like her cousin who was lying in bed and not being able to look after herself. This freeing up of her defences against change, meant that Anna began to consider the future, and that she had decided to see a solicitor and to create a Power of Attorney. She felt strongly that if, in the future, she was unwell, then she did not want to be resuscitated as she would not want to be weak and cared for.

At other times, however, if the therapeutic dialogue had been more threatening, then Anna responded more bluntly to the narcissistic injury thrust on her by the dementia. At these times, she firmly claimed there was nothing wrong with her brain - that nothing had happened to change her, or her memory.

There was a clearer glimpse of her anger and the rage that both she and Philip mentioned - of how the TV remote control would be thrown across the sitting room, or how furious she could become if she could not have her way.

Stiles has suggested that this movement between different positions or voices is a common element of therapy in people without cognitive impairments, especially when problematic material has been incompletely processed or assimilated (Stiles *et al*, 1990). This process of oscillating between approaching and retreating from the problematic diagnosis of dementia also occurs in people with dementia (Robinson, Clare and Evans, 2005). Indeed, it may be more pronounced for people with dementia precisely because their cognitive impairment makes it harder for people to hold onto therapeutic changes and gains. Thus, elsewhere this movement between dominant and problematic voices has identified in both couples (Snow, Cheston and Smart, 2015; and Lishman, Cheston and Gleeson, 2016) talking about their diagnosis and within group psychotherapy (Watkins et al, 2006; Cheston, Jones and Gilliard, 2004). Anna, then, continued to alternate between a dominant, false narcissistic self in which she voiced her omnipotence and a more problematic voice of change. In this latter position, she talked about her defences at one remove from them, rather than talking from within them.

Supporting a joint understanding

A central role of the therapeutic work was to offer support to Philip by seeing them together and by facilitating a joint dialogue about their life. The narcissist's behaviour forces others to either take the role of being crushed and dominated or to rebel in order to regain some control. Throughout our work, Philip had a patient and enormously tolerant ability to manage Anna's grandiosity. For him, our monthly therapeutic contact allowed him an opportunity to talk about and to make sense of what was happening. He spoke about rediscovering Anna - that her dementia hadn't made her a different person, it hadn't changed how she was, just made it more intense. In one session, Philip said that he had seen a TV programme about dementia in which a woman said that "*the condition doesn't define who you are*". This, Philip said, described Anna perfectly - she was still the same woman she had always been, and while her dementia was just another obstacle in her life, it didn't define her.

Working jointly with the person with dementia and their partner has a number of potential therapeutic advantages: it facilitates communication; enhances empathy; and prompts the recall of problematic experiences. Working with Anna and Philip together allowed us to discuss Philip's dilemma when Anna forgot something: it seemed that either he drew her attention to this (and risked being blamed by her for it) or he did nothing (and risk being blamed when things went wrong). During one session Philip described himself as an enabler, standing in the background and tactfully suggesting ideas rather than insisting on them. In response Anna said that without Philip's help she might have ended up like her sister - not going out - staying on her own and getting worse, helpless and weak.

Reflection

It has been argued that an apparent lack of awareness amongst people affected by Alzheimer's disease may act as a form of emotional regulation (e.g. Clare *et al*, 2011; Clare, 2002). This warding off of awareness may allow people to retain a psychological balance in the face of the significant existential threat that dementia represent (Cheston, Christopher and Ismail, 2015). Consequently, narcissism has a dual role to play for people with dementia: a healthy level of narcissistic regard can enable people to resiliently acknowledge their dementia without being overwhelmed by this existential threat. However, when high levels of narcissistic defences lead to the creation of a false self that is unable to acknowledge even the slightest degree of cognitive impairment, then this can create difficulties both for the person themselves, and for those around them. While Anna clearly fell back on her false self in which she continued to articulate a dominant voice of always being in the right, as we worked together, there were also clear indications that she was beginning to articulate some of the more problematic elements of dementia. In particular, she was clearly pained by the way in which her dementia made her feel stupid. At first, she could only articulate this indirectly, by projecting this fear into others. However, increasingly over the course of our work together, she began to acknowledge this more directly.

Nevertheless, in Stiles' terms, Anna continued to alternate between warding off her dementia, and a vague awareness of it. One obvious impact of dementia is the difficulty in laying down new memories that it creates for people. Within the context of psychotherapy, this may translate itself into problems in holding onto insights, in recalling significant events or implementing new strategies. Consequently, while a series of studies (Cheston, 1998; Cheston and Ivanecka, 2016) have shown that therapeutic change is possible for at least some people with dementia, it may well become harder for clients to hold onto new insights and ways of understanding themselves and their relationship to their dementia that are achieved within therapy.

Working with Philip was enabled him to develop his own narratives about Anna and her narcissism. In one session he described how they were participating in a research study looking at quality of life of people with dementia. When Anna had been asked about the impact of dementia on her life she continually joked and insisted again to the researcher that everything was well for her. Philip described how he felt that this jokiness was a defensive act - that it was too threatening for Anna to talk about her dementia. In doing this, he drew an analogy between Anna's difficulties in accepting the truth and Donald Trump. Just as Trump was always boasting and talking about fake news, so Anna, too, had her "*alternative truths*".

Summary

The reality of current dementia care is that while there has been significant progress in improving awareness of dementia symptoms and in achieving higher and more timely levels of diagnosis, there is often little recognition of the emotional challenge of dementia. Yet dementia acts as an existential threat onto which we project our worst fears: it is as if for each person who receives a diagnosis of dementia, the illness acts in the same way as Room 101 within George Orwell's *1984* - in which Big Brother's thought police confront prisoners with their worst nightmare, fear or phobia. Thus, for Anna, the worst aspect of dementia seemed to be the prospect of shame that comes with thoughts of being made "stupid". Consequently, as people with dementia begin to articulate the feared nature of the illness, so their levels of affect are likely to rise. For many people this is experienced as signifying a potential loss of control - embodied in feelings of panic, or distress as they move closer to their fears. Thus, as we help people to adjust to their dementia, so we may also begin to work with people who are frightened of a loss of emotional control.

The potential for psychotherapy in supporting this process of adjustment is considerable. However, the availability of therapy is still very limited, even if research in this area is steadily increasing and now stretches across most of the main therapeutic modalities (Cheston and Ivanecka, 2016). While the nature of the cognitive deficits inherent in dementia present challenges, these do not in and of themselves, mean that psychotherapy is impossible. Thus, the relative preservation of the amygdala compared to the hippocampus means that while it may be difficult to establish new memories, it may nevertheless still be possible to use therapy to help clients to emotionally process threatening material (Evans-Roberts and Turnbull, 2010). Moreover, in determining the capacity of a person to adapt to their dementia, so the social and personal resources that individuals have available to them are as important as the level and nature of the cognitive impairment in dementia. Where the personal resources available to people are thin, as is the case for those people who habitually fall back on narcissistic defences, then psychotherapy can play an important role in sustaining and enhancing their resilience. Given the significant potential for dementia to threaten the fragile bubble of self-importance that narcissists surround themselves with, psychotherapy can have both direct and indirect effects. Therapy can directly influence the ability of people to adjust to the illness, by enabling them to accommodate the problematic, threatening elements of dementia within a dominant, self-narrative of superiority. In addition, where a carer is also involved in the therapeutic process, then building a more sustainable discourse around dementia can also have indirect benefits.

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Table 1: Anna's scores on the ACE-III across the period of contact with memory services

	September, 2013	November, 2013	November, 2014	September, 2015
Orientation (max. total 18)	16 *	15**	13**	15**
Memory (26)	13**	11**	11**	6**
Fluency (14)	11	12	9*	9*
Language (26)	24	26	26	26
Visuo-spatial (16)	14	13*	9**	11**
Total (100)	78	77	68	67
Clock score (5)	5	5	2	2
Picture naming (10)	10	10	10	10
Geriatric Depression Scale (15)	3			
NART	107			
Bristol Activities of Daily Living (60)		7	4	3

* indicates scores representing impaired performance (less than 5th Percentile)
** indicates scores representing severely impaired performance (less than 1st percentile)