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Research Article

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Cold Therapy and Narcissistic Disorders of the Self

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Abstract

For well over a century, since the publication of Freud's seminal "On Narcissism" in 1914, pathological narcissism was widely considered to be a disorder of the "character" or the personality. This culminated in the 1980s and 1990s with the inclusion of Narcissistic Personality Disorder (NPD) in the third, fourth and text revision editions of the Diagnostic and statistical Manual (DSM).

Cold Therapy is based on two premises: (1) That narcissistic disorders are actually forms of complex post-traumatic conditions and not disorders of the personality; and (2) That narcissists are the outcomes of arrested development and attachment dysfunctions. Consequently, Cold Therapy borrows techniques from child psychology and from treatment modalities used to deal with PTSD.

Cold Therapy consists of the re-traumatization of the narcissistic client in a hostile, non-holding environment which resembles the ambience of the original trauma. The adult patient successfully tackles this second round of hurt and thus resolves early childhood conflicts and achieves closure rendering his now maladaptive narcissistic defenses redundant, unnecessary, and obsolete. In the process, both transference and countertransference are encouraged in order to most closely recreate the roles of the original "perpetrator" of abuse (abuser) and his or her victim (the patient or client).

Cold Therapy makes use of proprietary techniques such as erasure (suppressing the client's speech and free expression and gaining clinical information and insights from his reactions to being so stifled). Other techniques include: grandiosity reframing, guided imagery, negative iteration, other-scoring, happiness map, mirroring, escalation, role play, assimilative confabulation, hyper vigilant referencing, and re-parenting.

Paper

Reconceiving Pathological Narcissism

For well over a century, since the publication of Freud's seminal "On Narcissism" in 1914, pathological narcissism was widely considered to be a disorder of the "character" or the personality. This culminated in the 1980s and 1990s with the inclusion of Narcissistic Personality Disorder (NPD) in the third, fourth and text revision editions of the Diagnostic and statistical Manual (DSM).

There are four misconceptions about pathological narcissism:

a. It is not only a regression to an earlier childhood developmental phase;
b. It is not merely a psychological defense;
c. It is not simply an organizing principle or a schema;
d. It is not a personality disorder.

Pathological narcissism is a post-traumatic condition, amenable to trauma therapies. It is a reaction to prolonged abuse and trauma in early childhood or early adolescence. The source of the abuse or trauma is immaterial - the perpetrators could be parents, teachers, other adults, or peers. Pampering, smothering, spoiling, and "engulfing" the child are also forms of abuse.

Pathological narcissism is also not an adult disorder but an attachment dysfunction coupled with arrested development. It is therefore reactive to techniques borrowed from child psychology.

Finally: pathological narcissism can also be conceived not as a disorder of the self, but as an interpersonal disorder.

"When alarmed, child seeks proximity to caregiver (safe base). But proximity to frightening caregiver increases alarm" (Hazen and McFarland, 2010). The child reacts by attaching itself to an imaginary caregiver: the narcissist's False Self is godlike in its perfection, omniscience, and omnipotence. In some way, narcissism can be construed as a private religion with the False Self as the deity.

Re-traumatization as Healing

Foa and Kozak were the first to explore traumatization as a curative process (1985). It:

a. Resolves early conflicts;
b. Achieves closure;
c. Counters avoidance, helplessness, and depression

Via a controlled and tiered triggering of the client (trauma simulation, stressing) in a deliberately hostile and non-holding environment which aims to generate a facsimile of the environment of the Primary or Originating Trauma.

The adult patient emerges from the ordeal "alive and well": he survives the re-traumatization and successfully copes with it, this time as an adult.

The patient's maladaptive narcissism (cognitions, beliefs, emotions) is rendered redundant, unnecessary, and obsolete as a coping strategy. As a consequence of the principle of mental economy (the optimal allocation of mental resources to foster and uphold functionality), the client discards his pathological narcissism.

The construct of the False Self survives this process as godlike (private religion), an inverted and compensatory self-image, a signal (it elicits supply), a decoy for pain and hurt. It re-interprets the narcissist's behaviors and actions in a socially-acceptable light, and emulates (combines cold empathy with emotional resonance tables).

The Goals of Cold Therapy

Process trauma via skilled reliving
Foster more adaptive functioning
Replace negative with positive coping
Integrate distressing materials (thoughts, feelings, memories)
Lead to internal resolution and homeostasis
Aid the growth of skills: resilience, ego regulation, empathy

The Narcissist in Therapy

Narcissism pervades the entire personality. It is all-pervasive. Being a narcissist is akin to being an alcoholic but much more so. Alcoholism is an impulsive behaviour. Narcissists exhibit dozens of similarly reckless behaviours, some of them uncontrollable (like their rage, the outcome of their wounded grandiosity). Narcissism is not a vocation or a choice. Narcissism resembles depression or other disorders and cannot be changed at will.

Adult pathological narcissism is no more "curable" than the entirety of one's personality is disposable. The patient is a narcissist. Narcissism is more akin to the colour of one's skin rather than to one's choice of subjects at the university.

There are many types of narcissists: Overt/classic/grandiose, covert/shy/fragile/vulnerable, inverted, somatic, cerebral, acquired situational, high-functioning/exhibitionist,

Moreover, Narcissistic Personality Disorder (NPD) is frequently diagnosed with other, even more intractable personality disorders, mental illnesses, and substance abuse. Comorbidity is common with other personality, eating, mood disorders and autism spectrum disorders.

Treatment modalities used with narcissism: CBT/CEBT/REBT, DBT, Schema, Dynamic, psychoanalysis, Gestalt, Group therapy, and Cold Therapy.

Cognitive-Behavioural Therapies (CBTs)

CBTs postulate that insight – even if merely verbal and intellectual – is sufficient to induce an emotional outcome. Verbal cues, analyses of mantras we keep repeating ("I am ugly", "I am afraid no one would like to be with me"), the itemizing of our inner dialogues and narratives and of our repeated behavioural patterns (learned behaviours) coupled with positive (and, rarely, negative) reinforcements – are used to induce a cumulative emotional effect tantamount to healing.

Psychodynamic theories reject the notion that cognition can influence emotion. Healing requires access to and the study of much deeper strata by both patient and therapist. The very exposure of these strata to the therapeutic is considered sufficient to induce a dynamic of healing.

The therapist's role is either to interpret the material revealed to the patient (psychoanalysis) by allowing the patient to transfer past experience and superimpose it on the therapist – or to provide a safe emotional and holding environment conducive to changes in the patient.

The sad fact is that no known therapy is effective with narcissism **itself**, though a few therapies are reasonably successful as far as coping with some of its effects goes (behavioural modification).

Dynamic Psychotherapy, or Psychodynamic Therapy, Psychoanalytic Psychotherapy

This is **not** psychoanalysis. It is an intensive psychotherapy **based** on psychoanalytic theory **without** the (very important) element of free association. This is not to say that free association is not used in these therapies – only that it is not a pillar of the technique. Dynamic therapies are usually applied to patients not considered "suitable" for psychoanalysis (such as those suffering from personality disorders, except the Avoidant PD).

Typically, different modes of interpretation are employed and other techniques borrowed from other treatments modalities. But the material interpreted is not necessarily the result of free association or dreams and the psychotherapist is a lot more active than the psychoanalyst.

Psychodynamic therapies are open-ended. At the commencement of the therapy, the therapist (analyst) makes an agreement (a "pact" or "alliance") with the analysand (patient or client). The pact says that the patient undertakes to explore his problems for as long as may be needed. This is supposed to make the therapeutic environment much more relaxed because the patient knows that the analyst is at his/her disposal no matter how many meetings would be required in order to broach painful subject matter.

Sometimes, these therapies are divided to expressive versus supportive, but I regard this division as misleading.

Expressive means uncovering (making conscious) the patient's conflicts and studying his or her defences and resistances. The analyst interprets the conflict in view of the new knowledge gained and guides the therapy towards a resolution of the conflict. The conflict, in other words, is "interpreted away" through insight and the change in the patient motivated by his/her insights.

The supportive therapies seek to strengthen the Ego. Their premise is that a strong Ego can cope better (and later on, alone) with external (situational) or internal (instinctual, related to drives) pressures. Supportive therapies seek to increase the patient's ability to Repress

conflicts (rather than bring them to the surface of consciousness).

When the patient's painful conflicts are suppressed, the attendant dysphorias and symptoms vanish or are ameliorated. This is somewhat reminiscent of behaviourism (the main aim is to change behaviour and to relieve symptoms). It usually makes no use of insight or interpretation (though there are exceptions).

Group Therapies

Narcissists are notoriously unsuitable for collaborative efforts of any kind, let alone group therapy. They immediately size up others as potential Sources of Narcissistic Supply – or as potential competitors. They idealise the first (suppliers) and devalue the latter (competitors). This, obviously, is not very conducive to group therapy.

Moreover, the dynamic of the group is bound to reflect the interactions of its members. Narcissists are individualists. They regard coalitions with disdain and contempt. The need to resort to team work, to adhere to group rules, to succumb to a moderator, and to honour and respect the other members as equals is perceived by them to be humiliating and degrading (a contemptible weakness). Thus, a group containing one or more narcissists is likely to fluctuate between short-term, very small size, coalitions (based on "superiority" and contempt) and narcissistic outbreaks (acting outs) of rage and coercion.

Can Narcissism be cured?

Adult narcissists can rarely be "cured", though some scholars think otherwise. Still: the earlier the therapeutic intervention the better the prognosis. A correct diagnosis and a proper mix of treatment modalities in early adolescence guarantees success without relapse in anywhere between one third and one half the cases. Additionally, ageing moderates or even vanquishes some antisocial behaviour.

In their seminal tome, **"Personality Disorders in Modern Life"**, Theodore Millon and Roger Davis write

"Most narcissists strongly resist psychotherapy. For those who choose to remain in therapy, there are several pitfalls that are difficult to avoid ... Interpretation and even general assessment are often difficult to accomplish..."

The third edition of the **"Oxford Textbook of Psychiatry". "... People cannot change their natures, but can only change their situations. There has been some progress in finding ways of effecting small changes in disorders of personality, but management still consists largely of helping the person to find a way of life that conflicts less with his character ... Whatever treatment is used, aims should be modest and considerable time should be allowed to achieve them."**

The fourth edition of the authoritative **"Review of General Psychiatry". "(People with personality disorders) ... cause resentment and possibly even alienation and burnout in the healthcare professionals who treat them ... (p. 318) Long-term psychoanalytic psychotherapy and psychoanalysis have been attempted with (narcissists), although their use has been controversial."**

The reason narcissism is under-reported and healing over-stated is that therapists are being fooled by smart narcissists. Most narcissists are expert manipulators and consummate actors and they learn how to deceive their therapists.

Here are some hard facts

- There are gradations and shades of narcissism. The differences between two narcissists can be great. The existence of grandiosity and empathy or lack thereof are not minor variations. They are serious predictors of future psychodynamics. The prognosis is much better if they do exist.
- There are cases of spontaneous healing, Acquired Situational Narcissis, and of "short-term NPD" [see Gunderson's and Ronningstam work, 1996].
- The prognosis for a classical narcissist (grandiosity, lack of empathy and all) is decidedly not good as far as long-term, lasting, and complete healing. Moreover, narcissists are intensely disliked by therapists.

BUT

- Side effects, co-morbid disorders (such as Obsessive-Compulsive behaviors) and some aspects of NPD (the dysphorias, the persecutory delusions, the sense of entitlement, the pathological lying) can be modified (using talk therapy and, depending on the problem, medication). These are not long-term or complete solutions – but some of them do have long-term effects.
- The DSM is a billing and administration oriented diagnostic tool. It is intended to "tidy" up the psychiatrist's desk. The Axis II Personality Disorders are ill demarcated. The differential diagnoses are vaguely defined. There are some cultural biases and judgements [see the diagnostic criteria of the Schizotypal and Antisocial PDs]. The result is sizeable confusion and multiple diagnoses ("co-morbidity"). NPD was introduced to the DSM in 1980 [DSM-III]. There isn't enough research to substantiate any view or hypothesis about NPD. Future DSM editions may abolish it altogether within the framework of a cluster or a single "personality disorder" category. When we ask: "Can NPD be healed?" we need to realise that we don't know for sure what is NPD and what constitutes long-term healing in the case of an NPD. There are those who seriously claim that NPD is a cultural disease (culture-bound) with a societal determinant.

Narcissists in Therapy

In therapy, the general idea is to create the conditions for the True Self to resume its growth: safety, predictability, justice, love and acceptance - a mirroring, re-parenting, and holding environment. Therapy is supposed to provide these conditions of nurturance and guidance (through transference, cognitive re-labelling or other methods). The narcissist must learn that his past experiences are not laws of nature, that not all adults are abusive, that relationships can be nurturing and supportive.

Most therapists try to co-opt the narcissist's inflated ego (False Self) and defences. They compliment the narcissist, challenging him to prove his omnipotence by overcoming his disorder. They appeal to his quest for perfection, brilliance, and eternal love - and his paranoid tendencies - in an attempt to get rid of counterproductive, self-defeating, and dysfunctional behaviour patterns.

By stroking the narcissist's grandiosity, they hope to modify or counter cognitive deficits, thinking errors, and the narcissist's victim-stance. They contract with the narcissist to alter his conduct. Some even go to the extent of medicalizing the disorder, attributing it

to a hereditary or biochemical origin and thus "absolving" the narcissist from his responsibility and freeing his mental resources to concentrate on the therapy.

Confronting the narcissist head on and engaging in power politics ("I am cleverer", "My will should prevail", and so on) is decidedly unhelpful and could lead to rage attacks and a deepening of the narcissist's persecutory delusions, bred by his humiliation in the therapeutic setting.

Successes have been reported by applying 12-step techniques (as modified for patients suffering from the Antisocial Personality Disorder), and with treatment modalities as diverse as NLP (Neurolinguistic Programming), Schema Therapy, and EMDR (Eye Movement Desensitization).

But, whatever the type of talk therapy, the narcissist devalues the therapist. His internal dialogue is: "I know best, I know it all, the therapist is less intelligent than I, and I can't afford the top level therapists who are the only ones qualified to treat me (as my equals, needless to say), I am actually a therapist myself…"

A litany of self-delusion and fantastic grandiosity (really, defences and resistances) ensues: "He (my therapist) should be my colleague, in certain respects it is he who should accept my professional authority, why won't he be my friend, and after all I can use the lingo (psycho-babble) even better than he does? It's us (him and me) against a hostile and ignorant world (shared psychosis, folie a deux)…"

Then there is this internal dialog: "Just who does he think he is, asking me all these questions? What are his professional credentials? I am a success and he is a nobody therapist in a dingy office, he is trying to negate my uniqueness, he is an authority figure, I hate him, I will show him, I will humiliate him, prove him ignorant, have his licence revoked (transference). Actually, he is pitiable, a zero, a failure…"

And this is only in the first three sessions of the therapy. This abusive internal exchange becomes more vituperative and pejorative as therapy progresses.

Agnes Oppenheimer wrote this in the International Dictionary of Psychoanalysis:

"Mirror transference is the remobilization of the grandiose self. Its expression is: "I am perfect and I need you in order to confirm it." When it is very archaic, mirror transference can easily result in feelings of boredom, tension, and impatience in the analyst, whose otherness is not recognized. Counter-transference is thus a sign of it.

The notion, which first appeared in Heinz Kohut's work in "The Psychoanalytic Treatment of Narcissistic Personality Disorders" (1968), was further elaborated in his Analysis of the Self (1971). Mirror transference can take three forms, depending on the degree of regression and the nature of the point of fixation. Fusion transference is the most archaic form and refers to a primary identity relationship in which the other is completely part of the self. It shows itself when the analyst is taken to be omnipotent and tyrannical and is experienced as an extension of the self. In twinship or alter ego transference, the other is experienced as being like the self. Lastly, in mirror transference properly speaking, the analyst is experienced as a function in service of the patient's needs. If the patient feels recognized, he experiences a sense of well-being linked to the restoration of his narcissism.

Mirror transference can be primary, the reaction to a broken idealizing transference, or secondary to one of these. In The Restoration of the Self (1977), Kohut distinguished it from alter ego transference. Some authors have refused to consider this transference as being a result of the evolution of narcissism; they have seen it as a defense."

Narcissists generally are averse to being medicated. Resorting to medicines is an implied admission that something is wrong. Narcissists are control freaks and hate to be "under the influence" of "mind altering" drugs prescribed to them by others.

Additionally, many of them believe that medication is the "great equaliser" – it will make them lose their uniqueness, superiority and so on. That is unless they can convincingly present the act of taking their medicines as "heroism", a daring enterprise of self-exploration, part of a breakthrough clinical trial, and so on.

They often claim that the medicine affects them differently than it does other people, or that they have discovered a new, exciting way of using it, or that they are part of someone's (usually themselves) learning curve ("part of a new approach to dosage", "part of a new cocktail which holds great promise"). Narcissists must dramatise their lives to feel worthy and special. Aut nihil aut unique– either be special or don't be at all. Narcissists are drama queens.

Very much like in the physical world, change is brought about only through incredible powers of torsion and breakage. Only when the narcissist's elasticity gives way, only when he is wounded by his own intransigence – only then is there hope. It takes nothing less than a real crisis. Ennui is not enough.

Therapy with a narcissist client involves the following phases:

Presenting signs and symptoms
Clinical interview (anamnesis), diagnosis, prognosis
Psychological tests and their interpretation: NPI, MMPI-2, PCL-R, others
The patient's narcissistic defenses and resistances noted and the patient is made aware of them
Working without a therapeutic alliance or contract
Realistic therapy goals: behavior modification, reconciling lifestyle and choices with pathological/secondary narcissism, setting an extended timeframe, measurement of outcomes.

The Therapist

Treating the narcissist ("difficult patient") is a harrowing experience. On the therapist's side it involves:
Enduring idealization-devaluation cycles (being rapidly idealized and then devalued by the client)
Transference and countertransference (encouraged in Cold Therapy– see above)
Vicarious traumatisation
Activation of the therapist's own narcissistic defenses
Resentment, alienation, burnout, emotional exhaustion, trauma

Cooptation and collusion
Victimization
The formation of a shared psychosis/shared psychotic disorder (folies a deux)
Paranoid ideation
Cultlike settings in therapy with either the therapist or the client as the figurehead

Problems in Cold Therapy

Leveraging the False Self's grandiosity
Overcoming psychological defense mechanisms (like splitting) and magical thinking
Tackling cognitive deficits and distortions, thinking errors, fallacies, and failed reality test (e.g., Dunning-Kruger grandiosity)
The client's victim stance and internal working model
Grandiose, paranoid, and schizoid automatic thoughts
Contracting and alliancing with a hostile, grandiose, and resistant client
Managing and containing transference
Role of medication and placebos
Confrontation in the therapy's hostile environment fosters persecutory delusions
Narcissistic Rage and Shame
Distinguishing primary/originating traumas from secondary ones and avoiding CPTSD (using the Erasure and Hypervigilant Referencing techniques)
Comfort zone: Hostile, non-holding, unsafe environment leads to repetition compulsion, not to decompensation and acting out.

Cold Therapy Techniques

Only Level 1 techniques are listed but not in order of use!

Erasure

Serves to combine fear memory with absent information.
Metaphors: a cut cake provides more information than a whole cake, akin to reading between the lines in authoritarian regimes.
In erasure, we actively suppress certain words and expressions, in a form of censorship.
Phases:
Keywords selection guidelines
Keywords selection process (filtering for originating or primary trauma)
Speech suppression techniques: active (hushing) and passive (irrelevancing)
Speech recovery and interpretation of silences: gaps patterns, distribution, contextual gaps
Deconstructive/reconstructive narratives

Hypervigilant Referencing

Trauma and Abuse as narcissistic injury lead to hypervigilance: obsessive-compulsive behaviors and rituals, irritability and rage, sensory sensitivity, anxiety, arousal, exhaustion, scanning for threats and insults.
Referential ideation
Learn from the content of the delusional thinking about the locus of the primary/originating trauma.
Deconstruct the disparity between emotional and reality states

Grandiosity Reframing

Grandiosity as a cognitive distortion (Dunning-Kruger effect)
Grandiosity justified only inasmuch as it is an adaptation or a survival strategy.
Grandiosity provides capabilities to overcome traumas (it is a skill)
Grandiosity results in winning over the abuser
Leveraging grandiosity to get rid of it by telling the patient, for example: "When you are grandiose you are not acting optimally or efficiently, you are not a perfect machine."
Similar to strengthening the host in the treatment of DID (Dissociative Identity Disorder)

Guided Imagery (Imaginal technique)

Controlled catastrophizing (imagine the worst)
Controlled malignant optimism (imagine the fantastic)
Middling: locate the middle ground and render the adult the winner (by meeting the reality test)
Controlled depersonalization (deconstructing the False Self)
Controlled derealisation (life as a movie)
Validating reality: acknowledging transference and using the client's own language (echoing) while acknowledging his state of mind

Based on: **Exposure and Response Therapy**

Negative Iteration

Reframe situations and events as traumas
Design: coping strategies, winning strategies, defenses
Observe, hold (freeze), Rate distress (hot spotting), maintain (equilibrium), deconstruct, reframe (cognitive restructuring), and dispose
Based on: **Cognitive Processing Therapy**
Engender: personal safety, trust, power/control, and esteem, intimacy by reconsidering or reframing negative thoughts about self, others, and the world/environment
Assertiveness, communication, and social support
Repetition compulsion brought to awareness, mastered, obtains different outcomes, leads to resolution and reconciliation.
Example: Approach-avoidance Repetition Complex (Or Compulsion)

Happiness Map

Delineate the Happiness Space by compiling a list of happiness-inducing events and behaviors
Happiness Mapping: locate the common denominator by reduction (by drilling down the list and eliminating duplicates)
Intuitive Reactivity and Counterintuitive Reactivity and Denial

Mirroring

Client requested to play the Devil's Advocate via a dialectic: thesis (abuse, trauma), antithesis (not abuse, not trauma), synthesis (trauma is not an objective, "scientific" fact or event, but a subjective exegesis and reactive).

Escalation

Scenario construction: what could have been worse, what could have gone wrong?
Reality check/testing leads to gaining perspective and placing in proportion
Based on: **Cognitive Processing Therapy**

Role Play

Be an abuser (overt and covert techniques)
Be an abuser: identifying vulnerabilities
Patient as a therapist, parent, child, and adult
NPD as DID: the False Self on the chair. Moderator role shuttles between therapist and patient.

Based on: **Internal Family systems (IFS)**

Other-scoring

Part I

1. Self-evaluated thoughts
2. Thoughts about evaluation of others
3. Evaluative thoughts about others

What...
Do I think that s/he thinks about me?
Does s/he think that I think about him/her?
Do I think about him/her?
Does s/he think that I think that s/he thinks about me?
Do I think that s/he thinks about himself/herself?
Does s/he think that I think that s/he thinks about himself/herself?

Part II

4. Thoughts about coping strategies and behavioral plans
5. Thoughts of avoidance

In times of stress and crisis, what...
Do I think that s/he thinks I do best/I shirk or avoid/I fail in?
Does s/he think that I think s/he does best/shirks or avoids/fails in?
Do I think s/he does best/shirks or avoids/fails in?
Does s/he think that I think that s/he thinks I do best/I shirk or avoid/I fail in?
Do I think that s/he thinks that s/he does best/shirks or avoids/fails in?
Does s/he think that I think that s/he thinks that s/he does best/shirks or avoids/fails in?

Assimilative Confabulation

Identify: repressive gaps and dissociative gaps
Construct confabulations to bridge the gaps
Rank the plausibility of such confabulations
Demand the patient's ownership (assimilation) → Patient reacts with dystony or syntony
Dystony: Eg-discrepancy, discontinuity (disjointedness)
Syntony: Congruence, narrative coherence
Assemble core healthy, narratives about functioning and happiness
Share therapy notes with the patient

Reparenting

Transference and shared psychosis fostered and encouraged
Shift the parental locus of trauma to the therapist
Therapist owns the bad object
Splitting encouraged and leveraged and patient now owns the good object
Projective identification and introjective identification
Therapist picks up and contains via projective identification what patient cannot think about (unthought known)

Emotional Reregulation

From externalizing to internalizing
From grievance to task orientation
From counter dependence (contumacious defiance) to codependence
From social withdrawal to social functioning

Techniques from child psychology:

Emotional intensity control
Behavioral control (termination)
Interpretational of emotional cues (including own cues)
Interpretation of social cues
Avoidance and regression balancing
Focusing on the positive
Attention and focus control
Impulse control
Modelling (not demanding) desired behavior
Freedom vs. constraint and self-regulation
No over-stimulation
No excessive frustration
Identifying and countering discriminating thoughts and emotions
From internal construction to external representation

More about Cold Therapy:

Video

https://www.youtube.com/watch?v=Nh_gifvRh50

Lecture Notes

https://www.scribd.com/document/349440458/Cold-Therapy-Seminar-Level-1-Lecture-Notes

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