Psychotherapeutic Assessment and Treatment of Narcissistic Personality Disorder

By Robert C. Schwartz, Ph.D., DAPA
Shannon D. Smith, Ph.D., DAPA

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Abstract

Narcissistic personality disorder is a common and often disabling syndrome. Although persons with narcissistic personality disorder are often difficult to treat, certain psychotherapeutic strategies have been identified which can lead to effective interventions with these clients. This article presents strategies for assessing and treating narcissistic personality disorder during psychotherapy. Both theoretical and research literature is summarized in order to highlight useful approaches to working with clients manifesting narcissistic characteristics.

Key words

Assessment, diagnosis, treatment, narcissistic personality disorder

Narcissistic Personality Disorder (NPD) is essentially characterized as a long-term, pervasive character disorder that is defined by a consistent pattern of grandiosity, a strong need for admiration, and a distinct lack of empathy, which begins in late adolescence or early adulthood. Individuals diagnosed with NPD routinely overestimate their personal abilities, often appearing arrogant and boastful. They also tend to naturally believe that others ascribe the same importance to their abilities as they do. However, when praise or assumed value

is not forthcoming, they usually react swiftly and intensely. Such reactions may range from surprise and shock, to emotional deflation and depression, to extreme anger and hostility. These responses are generally thought to occur after the individual's sense of self-worth falters. More specifically, persons with NPD invariably have a very fragile sense of self-esteem that is dependent upon external validation (American Psychiatric Association [APA], 2000).

The underlying perception of helplessness, worthlessness, and fear of failure in clients with NPD often leads to the formation of psychological armor as an unconscious attempt to defend against intense personal shame. Outwardly, this armor is characterized by associating with others perceived as having "higher status" or social power. Inwardly, it takes the form of ruminating about overdue admiration from others, displays of privilege, idealization of a special few (e.g., "the best doctor in town") while the client outwardly devalues most others. Further, it can appear as a sense of entitlement in social situations, lack of sensitivity toward and exploitation of others, begrudging others' successes and possessions, and a total concern for one's own welfare.

In terms of categorical data, the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) has grouped NPD together under "Cluster B" personality disorders with its sister disorders (including Borderline, Histrionic, and Antisocial Personality Disorders). Beginning in early adulthood, an individual must demonstrate at least five of the following DSM-IV diagnostic criteria in any combination to qualify for NPD: a grandiose sense of self-importance; a preoccupation with fantasies of success, power, beauty, or brilliance; a belief that he/she is special and unique; a need for excessive admiration; a sense of entitlement; interpersonally exploitative behaviors; a lack of empathy for the needs of others; envy toward others and a belief that others are envious of him/her; and finally, arrogant, haughty behaviors. When conducting a clinical assessment, it is imperative for the psychotherapist to conduct a thorough review of each of the established criterion in an effort to ensure an accurate diagnosis. The therapist is also encouraged to employ an assessment instrument such as the Narcissistic Personality Inventory (NPI) (Raskin & Hall, 1979; Raskin & Hall, 1981; Raskin & Terry, 1988) to assist in the accuracy of the diagnosis.

The lifetime prevalence rate of NPD is approximately 0.5-1 percent; however, the estimated prevalence in clinical settings is approximately 2-16 percent. Almost 75 percent of individuals diagnosed with NPD are male (APA, 2000). Research has demonstrated that it is a common occurrence to find similar features of all the above characteristics in the same individual (Lilienfeld, Van Valkenburg, Larntz, & Akisal, 1986; Reise & Oliver, 1994; Cramer, 1999). Males tend to display more exploitative characteristics than females, as well as maintain a deeper sense of entitlement than females who have NPD. The co-occurrence of substance abuse is another common factor associated with this disorder, which also appears to be more common among men versus women with NPD (Tschanz, Morf & Turner, 1998).

NPD has been regarded as one of the most difficult pathologies to successfully treat (Lawrence, 1987). Beck and Freeman (1990) point out that when individuals with NPD actually engage in psychotherapy, it is primarily due to the symptoms of another disorder, most commonly depression. The lack of actively pursuing treatment for this condition is symptomatic of the disorder itself; individuals esteem themselves too highly to consciously consider the need for treatment. Some clients will project their grandiosity onto the therapist and develop a love-hate relationship. They are likely to approach therapy with a sense of entitlement and may seduce the therapist into supporting their sense of grandiosity.

One of the primary goals of psychotherapeutic treatment with clients having NPD is helping them build internally generated self-acceptance, without needing to either inflate the self or disparage others (McWilliams, 1994). A significant challenge is to help clients gain awareness and honesty toward the nature of their needs without stimulating their vulnerability to such an extent that internal shame hinders the therapeutic process.

Demonstrating patience during therapy is certainly required of therapists. One major complication often encountered during this process is that of countertransference. Such reactions evoked within these clients can include boredom and/or demoralization. Thus, it is important to remain inside the client's lived experience, so that true empathy can guide the clinical process. A consistent empathic stance will allow the psychotherapist to gain awareness of the client's moment-to-moment psychological responses and emotional needs. In addition, it provides clinical information that can be utilized in future sessions by the psychotherapist. For example, when countertransference reactions are induced within the psychotherapist, he or she can recognize that such experiences are indeed what the client may actually be feeling at a core level (McWilliams, 1994).

Another therapeutic guideline to be utilized when working with NPD clients is the modeling of acceptance and tolerance of human imperfection(s). Imperfections found not only within oneself, but also those blemishes within others, should be accepted non-judgmentally. These matter-of-fact assumptions, that all humans have flaws and that mistakes can be motivational and invigorating, may initially be foreign to these clients. However, when gently mirrored by employing an objective, supportive, nonjudgmental stance, the client is afforded the opportunity to slowly internalize a more positive and accepting attitude toward his or her inherent frailty. Conflicts that arise during the treatment of NPD can produce chronic feelings of emptiness, longing, fragmentation and confusion (Waska, 1996). Therefore, another important aspect of psychotherapy is the therapist's own acknowledgment of any therapeutic errors during therapy sessions. Particularly salient is making note of any lapses in empathy which may potentially impact the client in a negative manner. This should be done in a way that does not display a self-critical attitude on the part of the therapist, as to avoid demonstrating that mistakes are necessarily "wrong" and requiring self-censure.

Instead, this is accomplished through gentle questioning, combined with empathic mirroring of the client's needs. The psychotherapist is advised to slowly guide the psychotherapeutic process toward aiding the client to objectively understand his or her needs, and more importantly, how to meet such needs. For example, a psychotherapist might ask, "At the time when you felt angry due to your wife's 'insensitivity,' did you make your needs explicit?" (McWilliams, 1994).

The following case example illustrates the above treatment approaches when working with a client diagnosed with NPD. Charles, a 43-year-old man who never married, has been struggling with what he describes as his life-long history of relationship failure. He attributes this failure to his arrogance and selfishness, and simply demanding absolute perfection. He also described one separate occasion of becoming verbally explosive and mildly physically aggressive while under the influence of alcohol. Although he recognizes his pathology, he states, "I simply cannot change who I am. I guess I will never be able to have a relationship with anyone but myself!" This type of self-disparaging remark should be confronted with Charles. The therapist may assist Charles in recognizing his limitations by suggesting that mistakes often provide an opportunity for growth. Also, fostering a self-accepting attitude, the therapist would state the following, "Charles, we both agree that this incident was not an acceptable form of behavior. However, it appears as if you base your self-perception on this incident. You may recall that over the past year you have established several positive relationships, including your relationship with your new partner Jane and your recent reconciliation with your father." As the therapist holds Charles responsible for his unacceptable behavior, he also encourages Charles to focus on his positive relationship achievements.

The rationale for the above approach is to assist clients with NPD toward recognizing alternative methods, and ultimately more effective ways of responding behaviorally and emotionally. Thus, the client will succeed when attempting to fulfill his or her spoken and/or unspoken needs. More importantly, the client will attain such fulfillment without directly eliciting either shame (due to weakness about asking for something) or anger (due to other people not consistently fulfilling one's unspoken desires). By using constant mindfulness of the client's underlying internal self-state, the therapist can discern the appropriate psychotherapeutic pace while moving the client forward. Once again, this is accomplished in a safe, supportive psychotherapeutic environment as the client journeys through an often difficult and frightening path of change. Therefore, it is imperative that the therapist him or herself be certain to model a calm, caring, empathic, yet objective psychotherapeutic relationship with the client suffering with Narcissistic Personality Disorder.

About the Authors

Shannon D. Smith, Ph.D., PCC, NCC, DAPA, completed his M.A. in Pastoral Counseling at the University of Ashland, Seminary Division, Ashland, Ohio, and

his Ph.D. in Counseling from Oregon State University, Corvallis, Ore. He has worked as a Child and Family therapist in community mental health and as a school counselor in the public school system (K-12). Currently, he is an assistant professor in the Department of Counseling at the University of Akron, Akron, Ohio. His research interests include the diagnosis and treatment of major mental disorders, child and family therapy, school counseling, play therapy, counselor education and the use of technology in counseling. Of particular interest to Dr. Smith is the diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD) in children and adults.

Robert C. Schwartz, Ph.D., DAPA, graduated from the University of Florida with a doctorate in Mental Health Counseling. He is currently an Assistant Professor in the Department of Counseling and Director of the Clinic for Child Study and Family Therapy at the University of Akron in Ohio. He is a National Certified Counseling, a Certified Clinical Mental Health Counseling and a Licensed Professional Clinical Counselor in the State of Ohio. His research interests include depressive and personality disorders, schizophrenia and spirituality.

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