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Trying to Meet the Challenge of Psychotherapy for Narcissistic Personality Disorder

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Today's Agenda

- Description of the Problem
- Diagnostic Considerations
- Reviewing an Underlying Structure and Object Relations Theory
- Treatment Considerations

Why Focus on NPD Patients?

- **NPD is highly prevalent**
  - In general population (1 to 6.2%; 7.7% men; 4.8% women, Stinson et al, 2008)
  - In clinical samples (1% to 17%)
- **NPD represents a major public health problem**
  - Associated with functional distress and impairment in the spheres of love, work, and social life, more lethal suicidality (Grant, Hasin et al, 2004; Stinson et al, 2008)
- **Experience of our supervision group**
- **Everyone is talking about narcissism these days… a social as well as individual problem**

Why are Patients with NPD so difficult to treat?

- Tendency to provoke, control, devalue, and disengage therapist
- Cause distress, pain and suffering in others, **including the therapist**
- Tendency to demand special treatment and privileges
- Difficulty in acknowledging problems and/or verbalizing subjective experience;
- Tendency to retreat from contact with others—into an illusory world
- Enormous fear of exposure related to feelings of inadequacy, dependency, loss of status and control

Treatment research on NPD

- There are no evidence-based treatments for NPD
- There are no RCT's for treatments for NPD
- So you look for a "near-neighbor" condition that has an evidence base, BPD in this case.
  - What can you carry over?
  - What do you need to change?

DSM5 Criteria for NPD

- Grandiose sense of self importance
- Fantasies of success/power
- Believes self to be special and unique
- Requires excessive admiration
- Entitlement
- Interpersonally exploitative
- Lacks empathy
- Envious of others
- Shows arrogant, haughty behaviors

IS SOMETHING MISSING HERE?

- Certain clinical presentations
- An understanding of the dynamics

Different Modes of Expression of Narcissistic Pathology
(These are 2 sets of contrasting types, among others)

Grandiose	Vulnerable
Overt: Expressed in Attitudes and Behaviors	Covert: Expressed in Private Thoughts and Feelings

There is More Variability in Clinical Presentation in NPD than some other Personality Disorders

- In addition to the Overt-Covert Distinction, NPD shows a **broad spectrum of severity** from relatively healthy and high functioning out-patients to treatment-refractory in-patients

Given this Variability, How to Conceptualize NPD?

- It is possible to link them through a core psychological structure, a way the person has of experiencing themself and others

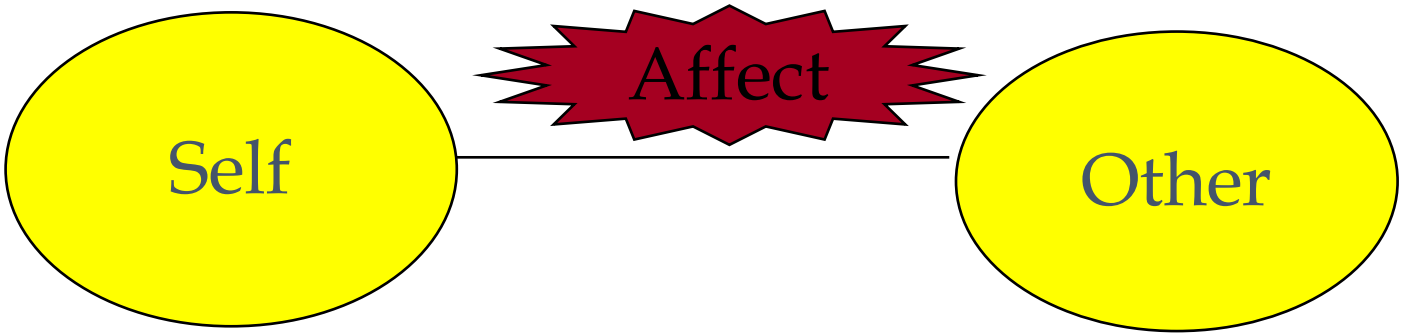
The Object Relations Theory Model of NPD

This model:

- Ties together different descriptive features by focusing on a specific psychological structure underlying the different presentations
- Focuses on intrapsychic mechanisms, especially on the impact of *defenses* on personality functioning
- Helps us to understand and empathize with the subjective experience of the individual with NPD
- Leads to the conceptualization of treatment approach

A Brief Review of Object Relations Theory

- Internal images of self in relation to an other are the most basic psychological structures
- These images organize subjective experience and are building blocks for higher order structures (e.g., ego, superego)
- They help understand the split psychological structure that is the basis for severe personality disorders



Different IORs activated in specific contexts

The IOR that is activated will organize expectations and experience of that setting

Early development:
Dyads and Splitting, illustrated in next slide

Primitive idealization –

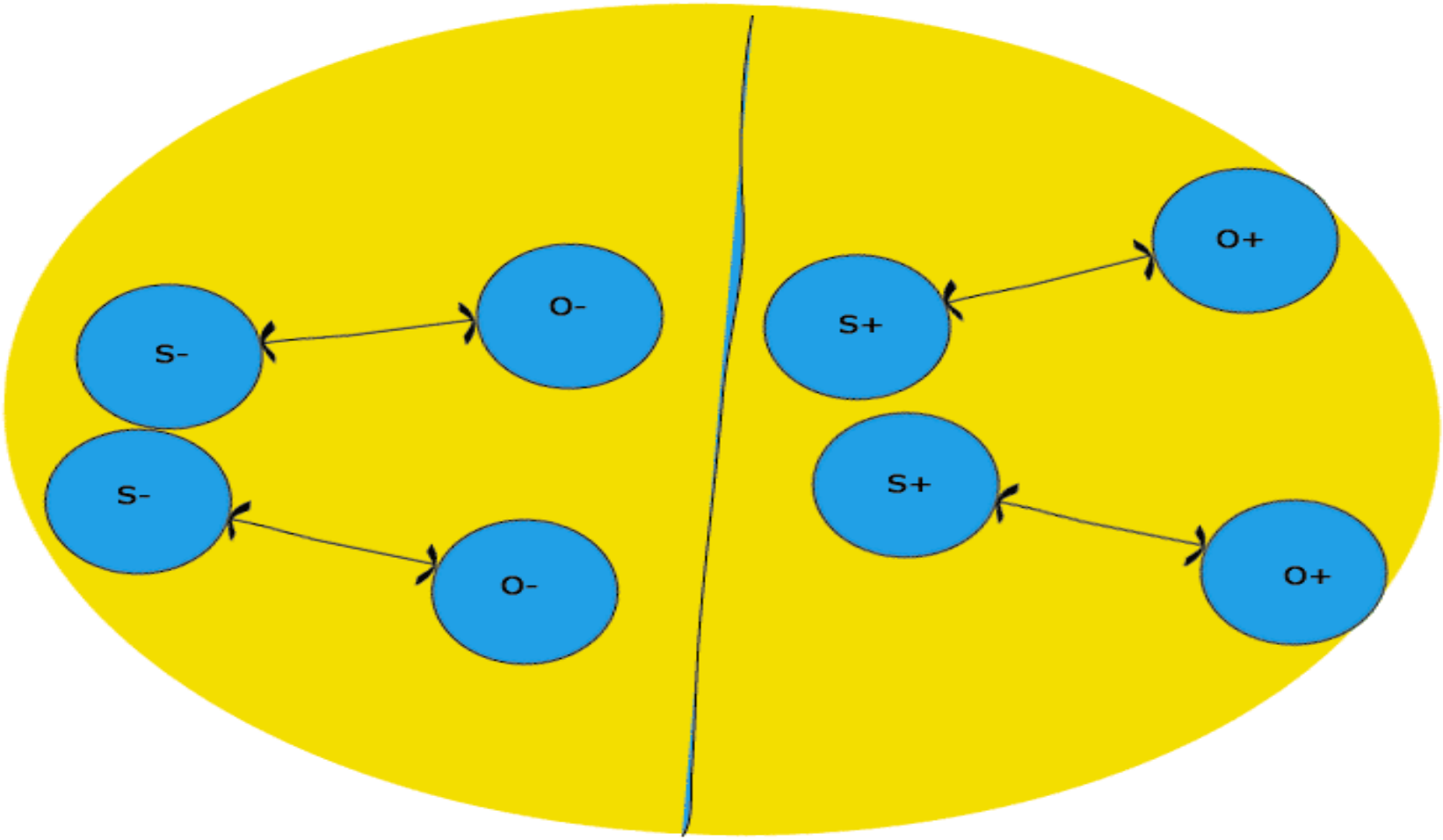
Memory traces based on experiences of satisfaction and pleasure; it results in an ideal sense of self and others, and the expectation that things will and should always be good.

Paranoid fears –

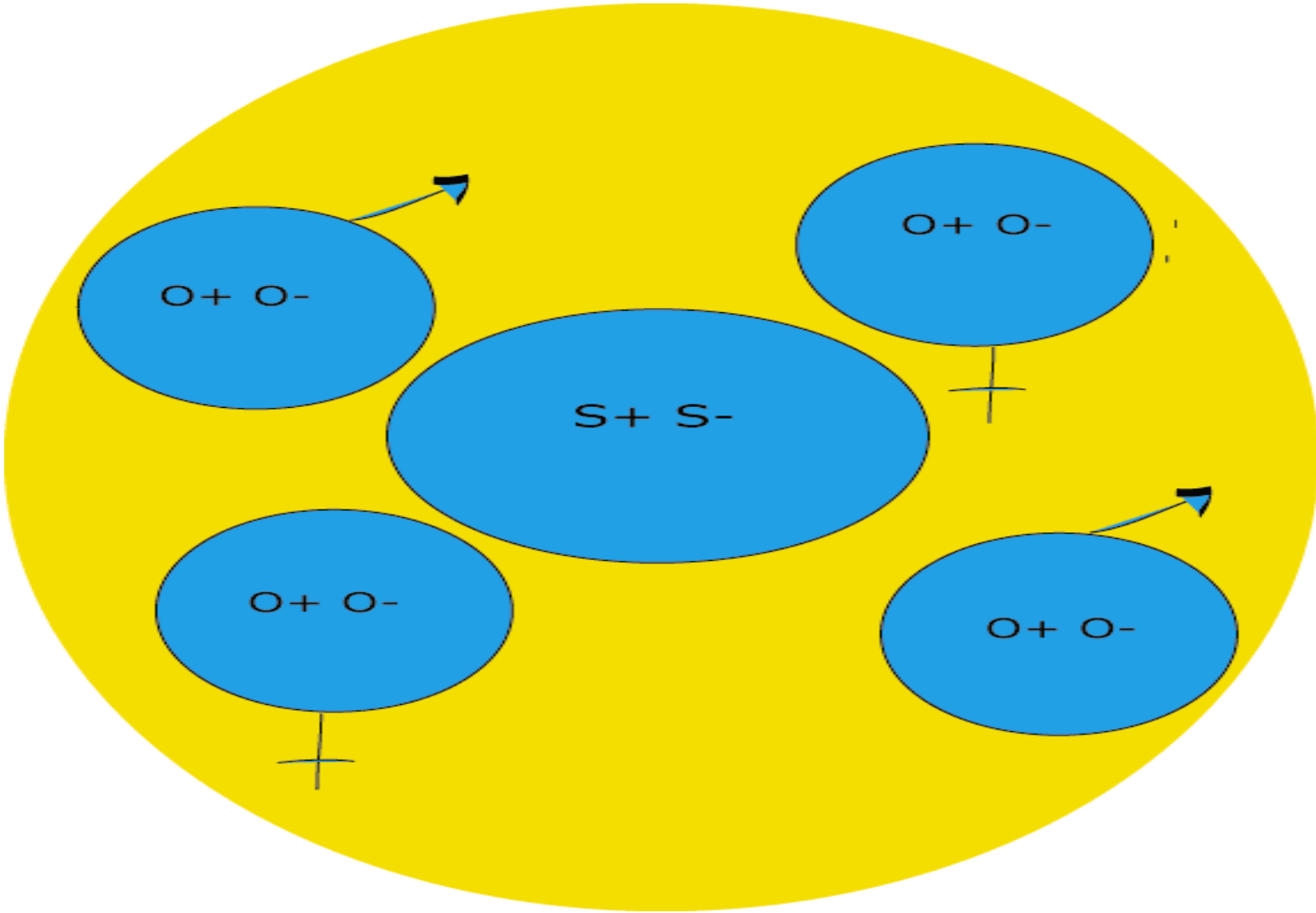
Memory traces based on experiences of pain and suffering that create a persecutory sense of others and hurt sense of self.

Brain studies

Split Organization:
The “Paranoid-Schizoid Position”
Consciousness of all-good/ideal or all-bad



Complex, Integrated Organization: The “Depressive Position”



Splitting and Identity Diffusion Characterize all Personality Disorders “organized at the Borderline Level”

Lack of identity integration – or **identity diffusion** – leads to a chaotic array of self states in Borderline Personality Disorder.

It is the core of all severe personality disorders

What about in NPD?

Borderline Personality Organization:

Extreme and Disconnected Dyads

The dyad activated by a trigger event determines the person's experience of the moment

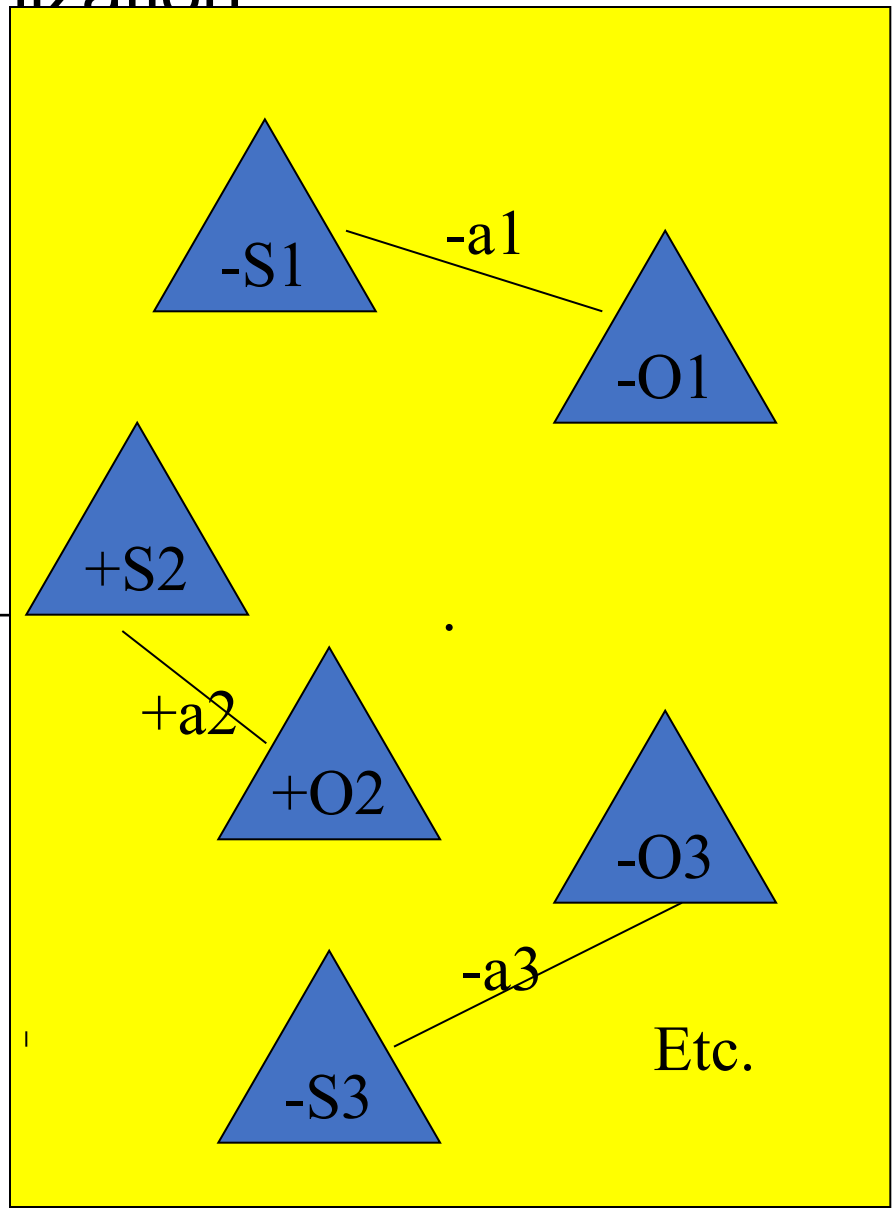
S = Self-Representation
O = Object - Representation
a = Affect

Examples

S1 = Victim
O1 = Abuser
a 1 = Fear

S2 = Childish-dependent figure
O2 = Ideal, giving figure
a2 = Love

S3 = Powerful, controlling figure
O3 = Weak, Slave-like figure
a3 = Wrath



In contrast, Narcissistic PD is defined by the Pathological Grandiose Self (PGS)

This is a self structure that appropriates all that is good and discards/projects all that is negative onto the other **in a relatively stable way**

It is a based on a Narrative of the Self that develops within the Individual

But it is a defensive structure – what does it defend against?

Example: ”When it’s time to work, I’ll run a movie studio”

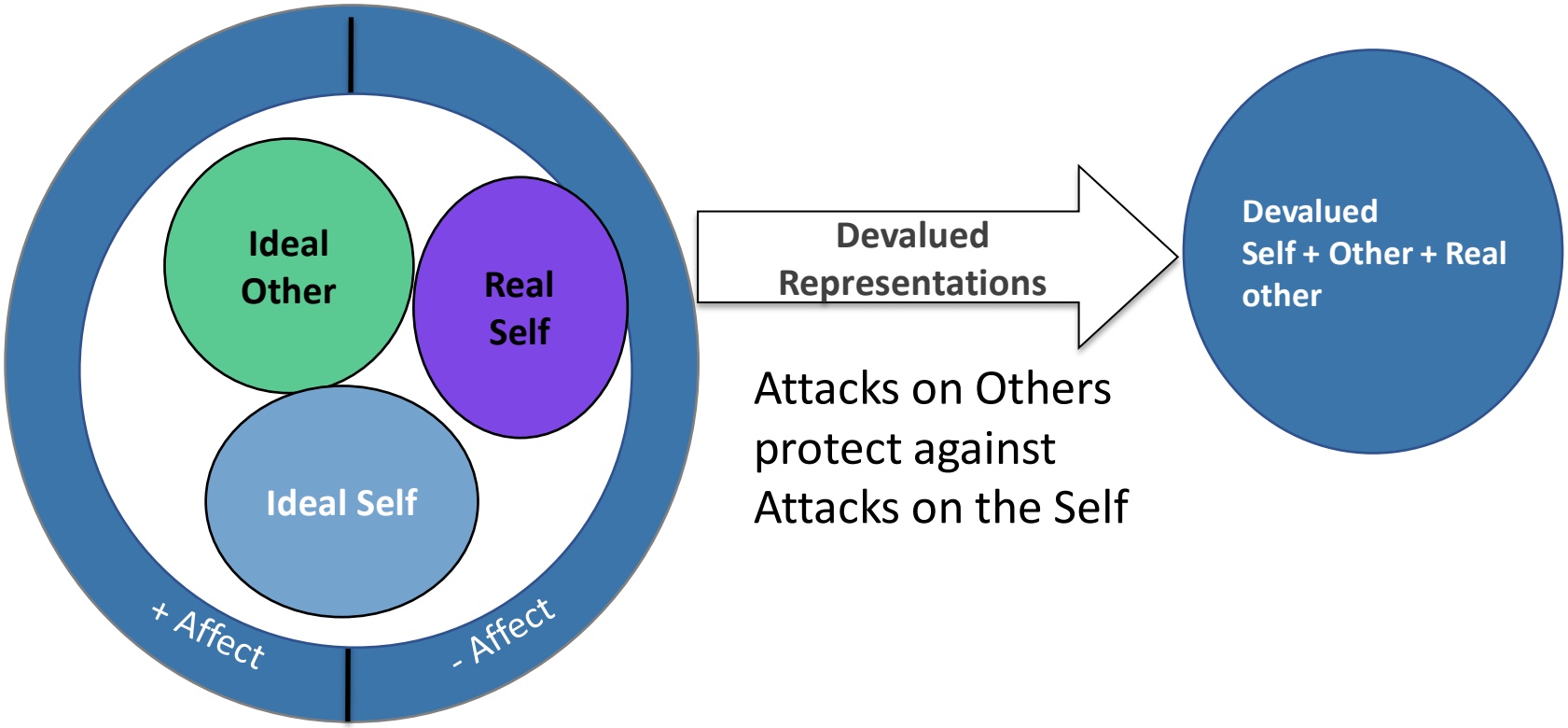
NPD is behind a lot of cases of Failure to Launch

Function of the Pathological Grandiose Self (PGS)

- It is a compensatory self structure that covers over the distress of the split, fragmented, and conflicted self
- It is a defensive *facsimile* of a unified identity
- It maintains view of self as exceptional, but also is superficial, distorted, and hollow
- It is rigid and brittle, requiring either
  - constant external support, or
  - withdrawal from external reality
- It leads to vulnerable reality testing

Pathological Grandiose Self

Sense of self comprised of all that is positive and ideal;
All that is negative is projected outwardly



The Grandiose Self protects against awareness of split affectively-laden dyads

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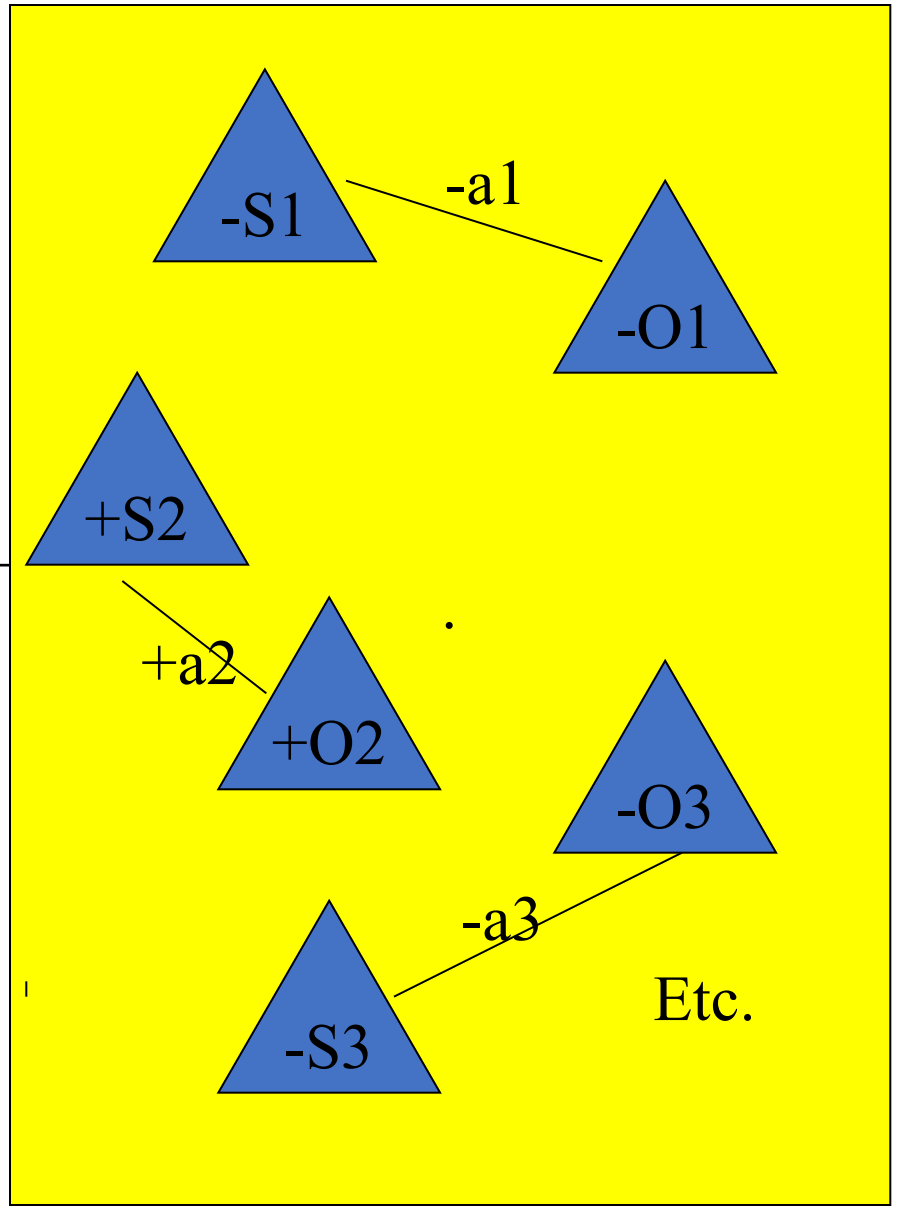
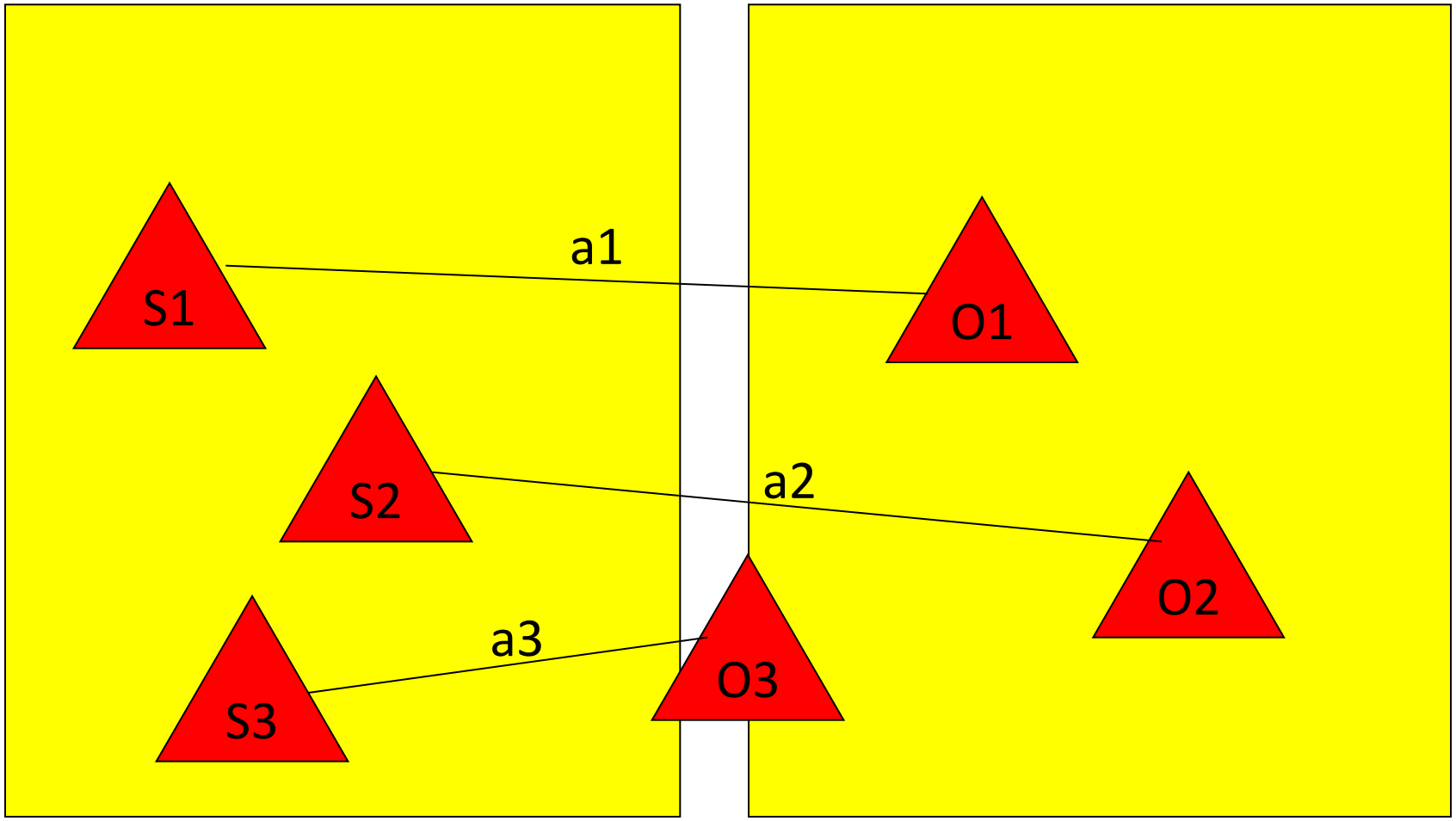


What about Treatment?

- Why do we focus on the transference?

Internal Images Organize the Sense of Self and Other

- Experience of Self
- …and of the other



A Difference between BPD and NPD

- In BPD, there are rapid shifts from one dyad to another (idealizing to paranoid) – the shifts give material to work with
- In NPD, the Grandiose – Devalued Dyad can stay rigidly in place (defending against dependency wishes)

Another Difference between NPD and BPD: Attachment Plays a Role

DISMISSING STATUS (NPD)

- Focus is continuously away from attachment relationships and their influence
- Deactivation of attachment
- Grandiose

PREOCCUPIED STATUS (BPD)

- Focus is persistently toward attachment relationships and their influences
- Hyperactivation of attachment
- Vulnerable

Implications of the object Relations Model for TREATING NPD

We need to:

1. Dismantle grandiose self
2. Uncover the underlying split structure
3. Promote normal identity integration

- Dismantling the grandiose self poses great challenge – there is a life or death quality for patient – his “self” is at stake

Questions of Technique with Narcissistic Patients: First, Diagnosis

- Many clinicians do not systematically assess for NPD
- Accurate evaluation and diagnosis is essential. Narcissistic pathology may underlie other clinical presentations, such as:
  - Depression – especially treatment resistant depression
  - Anxiety disorders
  - Obsessive compulsive disorder
  - Hypochondriacal disorder

Challenges of contract setting with NPD Patients: Setting up the frame

- Contract setting is more difficult because:
  - Discussing patient responsibilities challenges the grandiose self and the patient's exploitative, entitled, rule-breaking stance towards others;
    - "You have some responsibilities here"
  - Elements of the contract challenge NPD patients' retreat from the world;
    - "No therapy without some kind of activity in life"
  - Elements of the contract can puncture the idealization of the therapist (if it was there);
    - "I have no magic"

Getting to the Techniques of TFP

Managing technical neutrality (not taking sides in the patient's conflicts)

Utilizing countertransference awareness

The interpretive process:

- Consists of clarifying, confronting, and interpreting
- Addresses dissociative defenses

Conducting transference analysis (systematic analysis of distortions in the relationship)

Analysis of the Transference in NPD is more Challenging Because:

- The dismissive attachment style initially impedes the development of an affective relationship
  - The affects may be primarily in the countertransference
- The grandiose self obscures more specific split internal dyads; provides an illusion of integration
- The grandiose self protects against intense anxieties deriving from split internal world

So, our task is to help the patient tolerate and explore the anxieties motivating their retreat to the grandiose self

Technique with NPD Patients: Address the Manifestations of PGS

Focus on the process of communication and structure of language; how the patient expresses the self – **often the meaning is in the action:**

- Entertaining the therapist with scintillating anecdotes
- Drowning the therapist with material - Talking nonstop with no breaks or time for reflection [controlling]
- Inability to free associate; language used to conceal and manage the therapist's impression of patient rather than to reveal and explore internal world

Preparation for Interpretation: Containment and Symbolization of Affects. BPO Patient's Experience of the Transference

- The patient's experience of the therapist is concrete, with limited or no capacity to appreciate the distinction between internal and external reality
- The patient is initially not able to make use of traditional interpretations of underlying anxieties and defenses
- The patient may be able to use more basic interventions to contain/hold affective experience and to promote the capacity to cognitively represent it

Given the above, early interventions should focus on:

- Containment of affect
- Therapist-Centered Interpretations
- Countertransference

Therapist - Centered Interpretations (Interpretations in the Projection)

- Focus on the patient's immediate experience of therapist without linking it to the patient's conflicts or history

- Narcissistic patients initially cannot tolerate seeing flaws in themselves but may be able to observe them in the therapist and thus can reflect on what it is to have limitations.

Countertransference with Narcissistic Patients

- Therapist's self- reported countertransference responses yielded two major patterns:

1

Disengaged countertransference

- Lack of empathy and affective investment in the patient
- Feelings of boredom, frustration, avoidance,
- Desires to terminate the treatment

2

Angry/Distressed Countertransference

- Feeling like they are the brunt of the patient's contempt, denigration, criticism, devaluation, and anger
- Elicits feelings of anger and resentment on the part of the clinician

(Betan & Weston, 2005; Tanzilli, Colli, Muzi, Lingiardi, 2015).

Case example

- 35 year old woman, successful at work lonely and depressed, with suicidal ideation. Very eager to marry and have a family
- In spite of her chronic depression and suicidality, the patient believed she was the world's "moral compass"
- She chronically complained of others acting improperly
- She initially idealized the psychodynamic therapy to whom here previous CBT therapist had referred her
- Initial transferences:

  1) The well-behaved "good girl" in relation to expert therapist.

  2) The superior being in relation to a well-intentioned but devalued idiot

A Year into Therapy

"You've damaged me! I've gotten worse under your watch!"

Countertransferences:

- Reactive Aggressive
- Complementary via Projective Identification

The Intervention: to contain

Implicitly Challenging the "Superior-Inferior" Dyad

- The therapist's neutrality and honest curiosity are both an implicit confrontation of a "superior-inferior" model of relating and an invitation to experience and reflect on a relationship that involves mutuality.
- As these issues are addressed, it becomes possible to interpret at a deeper level the anxieties and that have maintained the retreat into grandiosity and devaluing, including anxieties about annihilation, abandonment and insignificance and aggression

In the Later Phases of Treatment

- The dissolution of the grandiose self leads to distress and apparent chaos that can make the patient look worse before he/she gets better
- The patient gradually experiences a conflict between his refuge in the grandiose self and some awareness of how seeking the ideal have eclipsed the needs of the real self
- The therapist often becomes the representative of the needs of the real self – of reality outside the grandiose self; he/she becomes a bridge to a real alternative to the “exquisite” grandiose isolation

Termination Comments

- “I’m more open with others now about my problems. I’m getting amazing responses. People are saying ‘I have this or that too’. I’m not hiding things like I used to. I used to hide them from me. I’m finding out that others can react with compassion - not the contempt I expected. I realize that for a long time I felt like a failure and had to pretend and hide. But it was the hiding that led to failure. Now I can be more real. I realize that if you’re pretending to be super-nice all the time, you won’t be caring about the right things. I was just trying so much so be someone I wasn’t.”

What haven’t we covered…?

- There are many more interesting aspects of NPD:
  - Malignant Narcissism
  - The Masochistic Narcissist
  - Negative therapeutic reaction based on envy
- And of researching psychotherapy:
  - E.g. What are the mechanisms of change?