2017 APS COLLEGE OF CLINICAL PSYCHOLOGISTS CONFERENCE

Experts in the assessment and treatment of complex mental health disorders

Workshop

Understanding and treating individuals with narcissistic personality disorder and those they affect

Ross King

Saturday 1 July 2017
9.30am - 5.30pm

#2017Clinical
Understanding & Treating Individuals with Narcissistic Personality Disorder & Those They Affect

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The Narcissism Epidemic?

To say, though, that narcissism is a singular plague of this decade or even of post–World War II American society is to engage in the same kind of, well, narcissistic thinking that afflicts those who continue to believe that adolescents nowadays are a special never-seen-before breed of human. To counter the latter misconception, pundits are wont to trot out some quotes from Plato or Socrates that reveal how ill-behaved and disrespectful youth were 2,500 years ago.

The assumption of a contemporary plague of narcissism might be similarly contested by reminding ourselves that the myth of Narcissus dates back at least 2,000 years to Ovid, if not before, and that throughout history multiple leaders (Caesar, Napoleon), literary creations (Gatsby), and societies (the city-state of Athens in ancient Greece) have been assigned this term. Nevertheless, it is instructive to consider the ways in which this age-old disorder or character trait is currently conceptualized.

Farber, B. Afterword: Our Narcissistic Age – or not. Journal of Clinical Psychology, 68, p. 955

Is Narcissism Increasing?

Research on empathy & narcissism been conducted for over 3 decades. In US college samples scores on the Narcissistic Personality Inventory been steadily rising & those on Interpersonal Reactivity Index, a measure of empathy, have been falling. About 70% of students score higher on narcissism & lower on empathy than average student 30 years ago (Twenge & Foster, 2010; Konrath, O’Brien, & Hsing, 2011).
It isn’t – it was just one study & it was the US so what would you expect
• 4 cross-sectional, 1 retrospective, & 4 longitudinal - same pattern.
• Studies been conducted in China, NZ and other places
It isn’t – NPI doesn’t measure narcissism but desirable characteristics – confidence, self-worth, assertiveness etc
• Other items refer to manipulating people & total score predicts N beh
• Measures like CPI & clinical interviews for NPD show same pattern
It isn’t – people are just more honest on the questionnaires.
• Impression-management on questionnaires remained stable
• Other measures like clinical interviews show similar changes
Why is it increasing?

It is – other signs are pointing to it

• Extrinsic values, unrealistic expectations, materialism, agentic but not communal self views, self-esteem (though mixed results), self-focus, less concern for others & the environment

It is – cultural markers are there

• Changes in pronoun use (I, me vs we & us) in books & song lyrics (I love me, I am special)
• Agentic words & phrases
• Decreasing moral words
• More emphasis on fame in tv shows for children & less on community

Why is it increasing?

It is – parents & others are creating it

• Parent attempts to build self-esteem through praise
• Greater emphasis on achievement & need to get ahead
• Everyone gets an award, trophy etc
• Reduction in play with other children- learn to control lives, solve problems & learn to interact with others – learn about sharing, negotiating, empathy etc

Based on Gray (2014), Twenge (2013), Quenqua (2013)
Why is it increasing?

Twenge (2011)- mechanism for cohort increases is sociocultural changes in parenting:

- Permissiveness
- Overindulgence
- Promotion of self-esteem independent of accomplishment


For alternate view:

Facebook & Narcissism: What Do We Know?

Mehdizadeh (2010)

- Facebook allows N to engage in many shallow relationships (virtual friends) through emotionally detached communications (Posts, comments etc).
- Allows control self-presentation - choose to post or use of photos to present image.
- 100 8-25 FB uni students completed NPI, self-esteem measure, & had FB page rated for self-promoting (About Me, first 20 photos, Status updates) features. Phrases containing positive adjectives or self-promoting mottos etc.
- N & SE predicted FB checks & time spent on FB.
- Sig correlation between N & self-promotion in Main Photo, View Photos, Status Updates & Notes.
Facebook & Narcissism: What Do We Know?

Bergman, Fearrington, Davenport & Bergman (2011)

- Examined does N predict reasons why Millennials use social networking sites.
- 374 undergrad 20yo, 53.6% male completed NPI
- No correlation N & amount of use, freq of updates, posting pictures of others or checking friends.
- Higher N predicted why use:
  - Having as many SNS friends as possible
  - Wanting SNS friends to know what they were doing
  - Belief that SNS friends interested in what were doing
  - Wanting their site profile to project positive image

Selfies & Narcissism: What Do We Know?

Fox & Roonie (2015) – 18-40 yo men
- NPI scores predict number of selfies posted in previous week.

- High N associated with > selfies over time (maintaining positive self-view) but > selfie production raised subsequent N (media effect hypothesis).

Weiser (2015) – representative sample of M & F aged 16-74
- Total NPI score & Leadership/ Authority (esp for F) & Grandiose Exhibitionism in both genders +ve associated with selfie posting freq
- Entitlement/ Exploitativeness only for men
- Age did not moderate this effect
Narcissism & Social Media: ?
McCain & Campbell (2016) – meta of 62 studies
Grandiose narcissism associated (r = .11 - .20) with:
- Time spent on social media
- Frequency of updates/tweets
- Number of friends/followers
- Frequency of posting selfies
- Culture & social media platform moderated results
- Vulnerable N not related to SMU – but small samples

Table 2 Ronningstam’s descriptors of healthy narcissism

<table>
<thead>
<tr>
<th>Description</th>
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<tbody>
<tr>
<td>Realistic self-appraisal of abilities and limitations</td>
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<tr>
<td>An ability to tolerate criticism and rejection as well as approval and praise</td>
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<tr>
<td>Grandiose fantasies that motivate achievement</td>
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<tr>
<td>An ability to internally control one’s sense of power and constructive aggression</td>
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<tr>
<td>A balanced sense of entitlement relative to others</td>
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<tr>
<td>Possession of empathy and compassion. An appreciation of commitment and mutuality</td>
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<tr>
<td>An ability to tolerate feelings of self-conscious emotions (envy, shame, pride) and inferiority and humiliation</td>
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</table>

5 tips to benefit from strengthening your own adaptive narcissism

1. **Build up some healthy narcissism to protect your own health.** Without becoming overly preoccupied with your appearance, include control over diet and exercise habits in your daily life.

2. **Don’t worry about how you look when you do work out.** Adaptive narcissism in college students benefitted fear of work out in public. Others more preoccupied about own appearance than yours.

3. **Find the right balance between assertiveness and reticence in leadership situations.** If natural leader, be likely to try to assume position of control when no-one else seems ready to take charge. As long as not crowding others out, go for it. If constantly taking over for fellow co-workers, might be time to take step back instead of forward.

4. **Turn up your empathy detector.** Those high in narcissism less likely to sense other people’s feelings because more tuned into own emotions. Even if got healthy narcissism, watch own blind spots.

5. **Try to help narcissists you know to see the light.** People high in less adaptive form of narcissism may take heart in knowing can turn weaknesses into personal strengths.

   – Susan Whitbourne 2012 *The healthy side of narcissism* Psychology Today
Miller, Lynam et al (2017) *Annual Review of Clinical Psychology*

- Warn against view that adaptive narcissism (as measured by NPI) is non-problematic
  - Sig correlated with symptoms of NPD
  - Correlates with DSM-5 Section 3 PD traits in domain of antagonism
  - Correlates with psychopathy
- Adaptive narcissism pathological when extreme & causes impairment
  - Linked to aggression (Rasmussen, 2016; Bushman, 2011) & IPV (Kiire, 2017)
  - Sexually predatory/ coercive behaviours (Blinkhorn et al, 2015; Ryan et al., 2008)
  - Behaviour in romantic relations (infidelity (Brewer, 2015), jealousy (Chin, 2016), negative communication)
  - Workplace settings (work performance (Meurs, 2013), interpersonal conflict, risk-taking)
- Therefore need to not just focus on subjective distress but also impact on others.

Freud (*On Narcissism, 1914*) believed that all infants pass through a phase of primary narcissism, in which they think they are centre of their universe. Normally, infant relinquishes its fantasy of omnipotence and becomes emotionally attached to its parents rather than itself.

Freud defined secondary narcissism as a pathological condition in which the infant does not invest its emotions in its parents but rather redirects them back to itself.
Views on Narcissism

Otto Kernberg (1970) emphasised good and bad self and object relations. Believed that operating within narcissist was set of characterological polarities:

(a) self-aggrandizement coupled with insatiable need for praise;
(b) charming exterior hiding ruthless interior; and
(c) presentation of independence & self-sufficiency masking intense envy.

Devaluation of others & sense of omnipotence used to maintain self-esteem & keep feelings of rage & envy in check.

Views on Narcissism

Heinz Kohut (1971) - narcissistic personality develops as response to parental empathic failures & subsequent feelings of being unlovable.

- to save lost perfection of mother-infant relationship, develops perfectly lovable “grandiose self” to ward off feelings of inadequacy & embarks on lifelong search for praise & adulation from which been deprived.
- Invests in this grandiose self not reciprocal relationships with others.
- Needs to be mirrored & confirmed by a self-object (i.e., person who exists to serve this function) such as therapist - mirror transference
- therapist not acknowledged as being separate being but rather extension of client or as set of functions merged with client self-experience.
Dark Personalities: Dark Triad

Dark personality traits - manipulation, exploitation, emotional coldness, & lack of empathy.

Psychopathy

• Callousness & interpersonal manipulation & antisocial & impulsive behaviour. Comprises:
  • Prim psychopathy – selfishness, callousness, lack of affect for others, superficial charm, chronic lying, lack of remorse
  • Sec psychopathy – susceptible to boredom, impulsivity, early behaviour prob & delinquency

• Machiavellianism
  • Strategic interpersonal manipulation, cynical world view, pursuit of self-benefit & power, strategic planning to achieve goals
  • Self-centred, focused on achieving power, money & status

Machiavellianism

• I tend to manipulate others to get my way
• I have used deceit or lied to get my way
• I have used flattery to get my way
• I have tended to exploit others towards my own end

• Psychopathy
  • I tend to lack remorse
  • I tend to be unconcerned with the morality of my actions
  • I tend to be callous or insensitive
  • I tend to be cynical


The Dark Triad: The Dirty Dozen

Machiavellianism

• I tend to manipulate others to get my way
• I have used deceit or lied to get my way
• I have used flattery to get my way
• I have tended to exploit others towards my own end

• Psychopathy
  • I tend to lack remorse
  • I tend to be unconcerned with the morality of my actions
  • I tend to be callous or insensitive
  • I tend to be cynical

• Narcissism
  • I tend to want others to admire me
  • I tend to want others to pay attention to me
  • I tend to seek prestige or status
  • I tend to expect special favours from others


### DSM-I vs DSM-II

<table>
<thead>
<tr>
<th>Cardinal PDs:</th>
<th>DSM-I</th>
<th>DSM-II</th>
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<tbody>
<tr>
<td>Paranoid</td>
<td></td>
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<tr>
<td>Inadequate</td>
<td></td>
<td>Schizoid</td>
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<tr>
<td>Schizoid</td>
<td></td>
<td>Cyclothymic</td>
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<td>Cyclothymic</td>
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<td>Antisocial</td>
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<td>Paranoid</td>
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<td>Explosive</td>
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<tr>
<th>Personality Trait Disturbances:</th>
<th>DSM-I</th>
<th>DSM-II</th>
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<tbody>
<tr>
<td>Emotionally unstable</td>
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<tr>
<td>Passive-aggressive</td>
<td></td>
<td>Asthenic</td>
</tr>
<tr>
<td>Compulsive</td>
<td></td>
<td>Inadequate</td>
</tr>
<tr>
<td>PTD, other</td>
<td></td>
<td>Obsessive-Compulsive</td>
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<thead>
<tr>
<th>Sociopathic Personality Disturbances:</th>
<th>DSM-I</th>
<th>DSM-II</th>
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<tbody>
<tr>
<td>Antisocial reaction</td>
<td></td>
<td>Passive-Aggressive</td>
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<tr>
<td>Dysocial reaction</td>
<td></td>
<td>Other</td>
</tr>
<tr>
<td>Sexual deviation</td>
<td></td>
<td>Unspecified</td>
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<tr>
<td>Addictions – alcoholism &amp; drug addiction</td>
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### DSM-III-R vs DSM-IV/IV-TR vs DSM-5

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<tbody>
<tr>
<td>Paranoid</td>
<td>Paranoid</td>
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<tr>
<td>Schizoid</td>
<td>Schizoid</td>
<td>Schizoid</td>
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<tr>
<td>Schizotypal</td>
<td>Schizotypal</td>
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<tr>
<td>Antisocial</td>
<td>Antisocial</td>
<td>Antisocial</td>
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<tr>
<td>Borderline</td>
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<tr>
<td>Histrionic</td>
<td>Histrionic</td>
<td>Histrionic</td>
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<tr>
<td>Narcissistic</td>
<td>Narcissistic</td>
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<tr>
<td>Avoidant</td>
<td>Avoidant</td>
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<tr>
<td>Dependent</td>
<td>Dependent</td>
<td>Dependent</td>
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<tr>
<td>Compulsive (O-C in III-R)</td>
<td>Obsessive-Compulsive</td>
<td>Obsessive-Compulsive</td>
</tr>
<tr>
<td>Passive-Aggressive</td>
<td>PDNOS</td>
<td>Personality Change Due to Another Medical Condition</td>
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<tr>
<th>DSM-III-R Appendix for further study</th>
<th>DSM-IV/IV-TR Appendix for further study</th>
<th>DSM-5 Other Specified PD/Unspecified PD</th>
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</thead>
<tbody>
<tr>
<td>Self-defeating</td>
<td>Depressive</td>
<td>Other Specified PD/Unspecified PD</td>
</tr>
<tr>
<td>Sadistic</td>
<td>Passive-Aggressive (Negativistic)</td>
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Conceptualising Personality Disorders

Livesley – evolutionary perspective

3 key life tasks must do to function in environment.

Failure or difficulty in 1 or > of tasks general sign of personality disorder.

- Achieve stable & integrated representation of self & others.
- Develop capacity for intimacy, to function adaptively as attachment figure & / or capacity for affiliative relationships.
- Function adaptively in social group, capacity for prosocial behaviour &/ or cooperative relationships.

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<table>
<thead>
<tr>
<th>Cluster</th>
<th>DSM-IV</th>
<th>ICD-10</th>
</tr>
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</table>
| A. Cluster | Paraphrenia | Paranoid, excessive suspiciousness, hypervigilance, 
| | Personality disorder or schizotypal personality disorder | Paranoid, excessive suspiciousness, preoccupation with perceptual or cognitive distortions, overestimation of events, misinterpretation of others |
| B. Cluster | Psychotic Disorders | Paranoid, excessive suspiciousness, preoccupation with perceptual or cognitive distortions, overestimation of events, misinterpretation of others |
| C. Cluster | Obsessive-Compulsive Personality Disorder | Obsessive-compulsive, preoccupation with cleanliness, perfectionism, control, orderliness, compulsions, rituals, 
| | Personality disorder | Obsessive-compulsive, preoccupation with cleanliness, perfectionism, control, orderliness, compulsions, rituals, 

DSM-5: General Definition Personality Disorders

- An enduring pattern of perceiving, relating to, and thinking about oneself deviating from expectations of one's culture manifested in 2 or > of:
  a). cognitions - perception of self others & events
  b). affectivity - range, intensity, lability & appropriateness
  c). impulse control
  d). interpersonal functioning
- inflexible & pervasive across broad range of personal and social situations
- Stable and of long duration & onset in adolescence or early adulthood
- impairs functioning or cause personal distress
- Not better accounted for by another mental disorder
- Not due to direct effects of substance or medical condition (e.g., head trauma, tumour)
Elaboration of DSM-IV Criteria

Grandiose sense of importance
- Overestimate abilities & inflate accomplishments – boastful & pretentious
- Assume others accord same value to achievements & surprised when not praised
- Underestimate accomplishments & contributions of others
- Preoccupied by fantasies of unlimited success, power, brilliance, beauty, ideal love – may ruminate over overdue admiration & compare self with famous, talented or privileged.

Belief in superiority
- Believe special, unique, & expect others to recognise this.
- Believe can only be understood by & should associate with other special or high status people & will attribute special qualities to them
- Needs are special & need only the best person (e.g. doctor etc) but will devalue those who disappoint them.

Require excessive admiration
- Self-esteem is very fragile
- Preoccupied by how well doing & how well regarded
- Need constant attention & admiration of self, possessions etc
- Will fish for compliments
- Sense of entitlement - expect special treatment – shouldn’t wait in line, priorities more important, frustrated when others don’t assist in “very important work.” May lead to conscious or unwitting exploitation of others.
- Expect to be given what want or need, no matter how affects others –overwork them
- Form friendships & relationships on basis of likely advancing career, desires, self-esteem.
Elaboration of DSM-IV Criteria

Lack Empathy

- Difficulty recognising desires, feelings, subjective experiences of others.
- Will discuss feelings at length but neglect to ask about others’
- Often contemptuous & impatient of others who talk about problems & concerns. View their needs etc as signs of weakness or vulnerability

Envious of others

- Begrudge others successes, possessions, feel they deserve them more
- Devalue contributions of others, esp those who receive acknowledgement or praise.

Arrogant & haughty

- Snobbish, disdainful, patronising
- Will complain about clumsy waiter as “rude” or “stupid”
- May conclude a medical evaluation with condescending evaluation of doctor.

Associated features

- Very sensitive to narcissistic “injury” as result of criticism or defeat
- May not show but leave them humiliated, degraded, hollow & empty
- May react with disdain, anger, or defiant counterattack.
- May socially withdraw or give appearance of humility to mask & protect grandiosity.
- Interpersonal relations impaired due to entitlement, need for admiration & insensitivity to others
- Ambition & confidence can lead to high achievement but performance disrupted due to intolerance of criticism or defeat.
- May have low vocational performance bc unwillingness to take risks if defeat possible.
Problem with DSM-IV NPD Criteria

DSM-IV-TR criteria for NPD currently captures **grandiose** Narcissistic personality traits, not **vulnerable** Narcissistic personality traits.

By placing most of the diagnostic emphasis on overt grandiosity, DSM NPD has been limited by poor discriminant validity, modest levels of temporal stability, and the lowest prevalence rate on Axis II.

(Chin, Pincus, Ansell, 2008)

Prevalence

**DSM-5**
- 0 – 6.2% in community samples
- 50-75% are males

Other Studies
- Ronningstam (2009) – 1.3%-17% in clinical population
- 5 clinical studies found rates from 0% - 22% with median of 2.3%
- 4 representative epidemiological studies found rates of 0% - 6.2% with median rate of 2.3%
- Dhawan et al. (2010) review – mean community prevalence of 1%.
Prevalence

However, figures vary greatly depending on method.


- 6.2% NPD but rating made by research assistants not clinicians.

- Trull et al (2010). Reanalysed data using different cut-off & found 1% (0.7% for males & 1.2% for females)

No longitudinal study conducted to see if clinical NPD increasing.

Comorbidity

Sustained feelings of shame or humiliation might lead to social withdrawal, depressed mood or actual major depressive disorder.

Sustained period of grandiosity might be associated with hypomania

Associated with:

- Anorexia nervosa
- Substance use disorders, especially cocaine
- Histrionic, borderline, antisocial & paranoid PD may be comorbid.
Differential Diagnosis

Borderline

• Interactive style grandiose rather than needy,
• N: Stable self-image vs B: unstable self-image, self-destructive, impulsive & abandonment fears

Histrionic

• Both draw attention to self
• N: Excessive pride in achievements, lack of emotional display, disdain for other’s sensitivities vs H: hyperemotionality, & dramatic, & seductive

Differential Diagnosis

Antisocial

• Both lack empathy, superficial, exploitative
• Typically callous, aggressive, impulsive, deceitful, not needing approval or admiration.
• N typically lacks criminal history

Obsessive-compulsive PD

• Both may desire perfectionism & believe others can’t do things as well.
• OCPD will be self-critical, NPD believes achieved perfection

Bipolar

• Manic or hypomanic may be grandiose but other symptoms & functional impairment present.
NPD: One factor or two?

Factor analysis of narcissistic personality traits consistently reveal two broad factors:

**Grandiosity/Exhibitionism or Overt Narcissism**
- associated with grandiosity, social charm, failure to respond to needs of others, invulnerability, entitlement, aggression & dominance.

**Vulnerability-Sensitivity-Depletion or Covert Narcissism**
- uses grandiose behaviour to mask hypersensitivity to criticism, self-doubt, deep feelings of inadequacy, incompetence, inferiority, worthlessness and negative affect.

(Wink, 1991)
Narcissistic Personality Disorder: One factor or two?

- Grandiose N primarily reflects traits related to grandiosity, aggression, and dominance; consistent with Freud’s (1931/1964) conceptualization of this personality (“libidinal”) type.
- Vulnerable narcissism reflects defensive & fragile grandiosity in which grandiosity serves as facade obscuring feelings of inadequacy, incompetence, & negative affect; more consistent with Kernberg’s (1984) notion of narcissism.

Ronningstam (2009) contrasts individuals with grandiose forms of narcissism with the inhibited, shame-ridden, and hypersensitive shy type, whose low tolerance for attention from others and hypervigilant readiness for criticism or failure makes him/her more socially passive . . . . nevertheless, under a modest surface, the shy narcissistic individual is equally preoccupied with self-enhancing fantasies and strivings and hyperreactive to oversights and unfulfilled expectations from others. (p. 113)

| Russ, Sheder et al. (2008) |
|---|---|
| **Fragile** |
| Core features: |
| Interpersonal vulnerability |
| Underlying emotional distress |
| Fear rejection and abandonment |
| Feel misunderstood, mistreated, or victimized |
| Extreme reactions to perceived sights or criticism |
| Feel unhappy, depressed, despairing, and anxious |
| Anger, hostility |
| Subtype features: |
| Splitting, ruminating on rejection, and inadequacy |
| Grandiosity—defensive against painful feelings of inadequacy, smallness, anxiety, and loneliness |
| Grandiosity—emerging under threat |

| Grandiose/Malignant |
| Core features: |
| Interpersonal vulnerability |
| Underlying emotional distress |
| Fear rejection and abandonment |
| Feel misunderstood, mistreated, or victimized |
| Extreme reactions to perceived sights or criticism |
| Feel unhappy, depressed, despairing, and anxious |
| Anger, hostility |
| Difficulties regulating affects |
| Interpersonal competitiveness |
| Power struggles |
| Externalize blame |
| Subtype features: |
| Exploits others, primary grandiosity |

| High-Functioning/Exhibitionistic |
| Core features: |
| Interpersonal vulnerability |
| Underlying emotional distress |
| Fear rejection and abandonment |
| Feel misunderstood, mistreated, or victimized |
| Extreme reactions to perceived sights or criticism |
| Feel unhappy, depressed, despairing, and anxious |
| Anger, hostility |
| Difficulties regulating affects |
| Interpersonal competitiveness |
| Power struggles |
| Externalize blame |
| Subtype features: |
| Grandiose |
| Competitive |
| Attention Seeking |
| Sexually seductive |
| Articulate |
| Engaging |
| Interpersonally comfortable |
| Achievement oriented |

Narcissists virtually always exhibit both covert & overt grandiosity & covert & overt vulnerability.

**Overt grandiosity** - patient threatened people who parked in apartment’s parking space. Called T to report planned to buy gun & shoot next person parked there. Patient did not own car and did not drive.

**Covert grandiosity** such as in grandiose fantasies. Patient at midlife, was unemployed, socially isolated, & lived in parents’ basement. Patient spent most days fantasizing about being loved & admired head of own philanthropic organization while concurrently lacking any motivation or effort to address current social, occupational & psychological deficits.
Narcissistic vulnerability can also be expressed overtly and covertly.

**Overt vulnerability** - angry dysregulation & suicidal reactions to narcissistic injury. Patient so distraught after hearing trust fund exhausted made strategic suicide attempt (overdose) timed so mother would find him unconscious when arrived for weekly shopping trip.

**Covert vulnerability** - shame, social withdrawal, & devaluation of self in reaction to unmet idealized expectations. Patient did not make positive impression & elicit admiration from new neighbors became depressed & ashamed, punishing himself by not eating for days.

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**What Leads to NPD?: Biological**

Both NPD & narcissistic traits are about 40% heritable.

**Neuroanatomical:**

**Schulze et al. (2013)** *J of Psychiatric Research, 47,* 1363-1369

*Grey matter deficits in left anterior insula & bilateral superior & middle frontal gyri, cingulate cortices & pre/post central gyri*

**Nenadic et al (2015)** *Psychiatry Research: Neuroimaging* 231, 184-186 - 6 male NPD cf to 48 controls

- Detected gray matter deficits in right middle frontal gyrus & left medial prefrontal cortex/ anterior cingulate cortex, left middle occipital cortex, left fusiform/ inferior temporal cortex, superior temporal cortex, left lingual gyrus
- Detected white matter deficits in right frontal lobe (under superior /middle prefrontal gyrus, right anterior thalamic radiation, left anterior/lateral temporal lobe & right brain stem

Right prefrontal & bilateral medial prefrontal pathology may be linked to emotional regulation difficulties or cognitive deficits in attribution or coping

Anterior insular linked to empathy.
What Leads to NPD?

Paris (2014) – Biopsychosocial perspective
Environmental influences also important – siblings in same house do not have same traits.
Risk factors suggest:
- Permissiveness for grandiose narcissism – cultural trend towards parental & social reinforcement of grandiosity
- Cold overcontrol in vulnerable narcissism

Twenge (2011)- mechanism for cohort increases is sociocultural changes in parenting:
- Permissiveness
- Overindulgence
- Promotion of self-esteem independent of accomplishment

What Leads to NPD?: Parenting


- 4 x 6 monthly waves of assessment with 565 children (age 7-12) & parents.

Children reported:
- narcissism (10-item childhood narcissism scale – kids like me deserve something extra
- Self-esteem
- Parental warmth – my father/ mother lets me know he/she loves me

Parents reported:
- Parent overvaluation – my child is more special than other children
- Parental warmth
- Support social learning theory – narcissism predicted by parent overvaluation – internalise parent’s inflated views of them
- No support for psychoanalytic theory – lack parental warmth did not predict narcissism
What Leads to NPD?: Parenting
Adolescent narcissism & parenting

300 adol high school dropouts in short-term residential program reported:

- Pathological narcissism – both grandiose & vulnerable narcissism
- Parenting practices
  - Positive reinforcement – praise & rewards
  - Parental involvement – spending time together
  - Inconsistent discipline – not applying punishment
  - Poor monitoring/supervision – knowing where child is
- Vulnerable narcissism correlated with inconsistent discipline
- Grandiose narcissism linked to positive reinforcement & parental involvement

What Leads to NPD?

*Children in the Community study (Johnson et al. 1999, Archives of Gen Psychiatry)*

- Children interviewed at baseline in 1975 aged 1-11
- Followed up in young adulthood (1991-1993) M age 22 years (18-28)
- Childhood maltreatment from NY registry & participant retro self-report.
- If documented child abuse or neglect 4x > PD in adulthood.
- Physical abuse associated with antisocial & borderline traits.
- Neglect – antisocial, borderline, narcissistic, avoidant & dependent traits.
- If child abuse or neglect had sig > odds of antisocial (OR=5.0), borderline (7.7) or narcissistic (18.2) PDs
What Leads to NPD?

Paris (2014) – does increasing emphasis on individualism as opposed to collective have role?

• If traditional social structures weaken, do people focus less on conforming to external expectations & more on inner feelings & what will lead to personal satisfaction.

• Those with NPD have low agreeableness, low conscientiousness, & high neuroticism – may interfere with adaptive responses to social stressors.

Twenge, Miller & Campbell (2014) - studies of US high school children show they have:

• Unrealistically high expectations regarding educational & vocational attainment

• Expect to perform at highest level in important adult roles

• Have higher self esteem than those in 1980s

Assessing Narcissism & NPD

Narcissistic Personality Inventory

• 40 item forced-choice measure

• e.g. “I am more capable than other people” vs “There is a lot I can learn from other people.”

3 factors:

• Leadership/ Authority – self-perception as leader, dominance & capacity for social agency – motivated to seek power & authority

• Grandiose Exhibitionism – self-absorption, vanity, exhibitionistic tendencies – crave attention, enjoy showing off & crave attention

• Entitlement/ Exploitiveness – entitlement, sense deserve respect, & willingness to exploit other - have unreasonable expectations of favourable treatment, believe deserve what they wish, take advantage of others in service of goals.


*Measures trait narcissism not NPD

Assessing Narcissism & NPD

Pathological Narcissism Inventory

52 items - 1 (Not at all like me) to 6 (Very much like me)

2 subscales:

- **Grandiosity** – 18 items – “I often fantasise about being admired & respected
- **Vulnerability** – 34 items – “I sometimes need important others in my life to reassure me of my self-worth”


**Brief Pathological Narcissism Inventory**

- Based on best performing 28 items of PNI


Source:
Assessing Narcissism & NPD

**Five-Factor Narcissism Inventory**

- 147 items - 1 (Strongly disagree) to 5 (strongly agree)
- Designed to tap into maladaptive variant of FF traits associated with vulnerable & grandiose narcissism
- 15 subscales:


Assessing Narcissism & NPD

Five-Factor Narcissism Inventory

1. Reactive Anger (e.g., “I have at times gone into a rage when not treated rightly”).
2. Shame (e.g., “When I realize I have failed at something, I feel humiliated”).
3. Indifference (e.g., “Others’ opinions of me are of little concern to me”).
4. Need for Admiration (e.g., “I want so much to be admired by others”).
5. Exhibitionism (e.g., “I enjoy being in front of an audience or big crowd”).
6. EPA Thrill-Seeking (e.g., “I like to have new and exciting experiences, even if they are a little frightening”).
7. Authoritativeness (e.g., “I tend to take charge of most situations”).
8. Grandiose Fantasies (e.g., “I daydream about someday becoming famous”).
9. EPA Cynicism/Trust (e.g., “You have to look out for your own interests because no one else will”).
10. Manipulativeness (e.g., “I will mislead people if I think it is necessary”).
11. Exploitativeness (e.g., “If people are ignorant enough to let me take advantage of them, so be it”).
12. Entitlement (e.g., “I believe I am entitled to special accommodations”).
13. Arrogance (e.g., “I only associate with people of my caliber”).
14. Lack of Empathy (e.g., “I’m not big on feelings of sympathy”).
15. Acclaim-Seeking (e.g., “I have devoted my life to success”).

DSM-5 Dimensional Approach to Personality Disorders

- Hybrid dimensional-categorical approach
- Reconceptualization of personality psychopathology with:
  - core impairments in personality (self & interpersonal) functioning
  - pathological personality trait domains & trait facets
  - prominent pathological personality types.
- Personality disorder diagnosed when core impairments & pathological traits are present & other criteria met.
Alternate DSM-5 General Criteria for Personality Disorder

Essential features
A. Moderate or > impairment in personality (self/interpersonal) functioning.
B. One or more pathological personality traits.
C. Impairments in personality functioning & personality trait expression relatively inflexible & pervasive across broad range of personal & social situations.
D. Impairments in personality functioning & personality trait expression relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood.
E. Not better explained by another mental disorder
F. Not solely attributable to substance or medical condition
G. Not better understood as normal for developmental stage or sociocultural environment.

Alternate DSM-5 Personality Disorders

Self:
• **Identity**: Experience of oneself as unique, with clear boundaries between self & others; stability of self-esteem & accuracy of self-appraisal, capacity for, and ability to regulate, a range of emotional experience.

• **Self-direction**: Pursuit of coherent & meaningful of both short-term and life goals, utilisation of constructive and prosocial internal standards of behavior; ability to self-reflect productively

Interpersonal:
• **Empathy**: Comprehension and appreciation of others’ experiences & motivations; tolerance of differing perspectives; understanding effects of own behavior on others

• **Intimacy**: Depth & duration of positive connection with others; desire & capacity for closeness; mutuality of regard reflected in interpersonal behavior
Proposed PD Version 1

- Original proposal version had 5 PDs but not narcissistic PD
  - However, criticism proposed trait dimensions inadequately cover narcissism.
- Levy et al. (2013) summarised issues as:
  - NPD covered by only 4 traits - retained PDs described by 9-11
  - Traits considered essential to NPD such as maladaptive levels of extraversion, agreeableness, & low neuroticism excluded
  - Broadening NPD criteria to include items of narcissistic vulnerability, competitiveness, & hostility would reduce overlap with other PDs

Levy et al. (2013). Narcissism in the DSM. In J.S. Ogrodniczuk (Ed.), Understanding & treating pathological narcissism. American Psychological Association

DSM-5 Dimensional Approach to Personality V2

- 6 personality disorder (PD) types:
  - Schizotypal
  - Narcissistic
  - Borderline
  - Antisocial
  - Avoidant
  - Obsessive-Compulsive
  - plus Personality Disorder Trait-Specified

- Each defined by core PD components & subset of 5 broad, higher order personality trait domains:
  - Negative Affectivity vs Emotional Stability
  - Detachment (Introversion) vs Extraversion
  - Antagonism vs Agreeableness
  - Disinhibition vs Compulsivity
  - Psychoticism vs Lucidity

- comprising subset of 25 more specific trait facets
### Levels of Personality Functioning Scale

**Source:** DSM-5 American Psychiatric Association

<table>
<thead>
<tr>
<th>Level of Impairment</th>
<th>Self</th>
<th>Interpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Id.</td>
<td>Self-direction</td>
<td>Empathy</td>
</tr>
<tr>
<td>2—Moderate Impairment</td>
<td>Depends excessively on others for identity definition, with compromised boundary definition. Has vulnerable self-esteem, controlled by exaggerated concern about external evaluation, with a wish for approval. Has sense of incompetence or inferiority, with compensatory inflated, or delusional, self-appraisal. Emotional regulation depends on positive external appraisal. Thinks in self-esteem may engender strong emotions such as rage or shame.</td>
<td>Goals are more often a source of gaining external approval than self-directed, and thus lack coherence and/or stability. Personal standards may be unreasonably high (e.g., a need to be special or please others) or low (e.g., not consistent with prevailing social values). Fulfilment is compromised by a sense of lack of authenticity. Has impaired capacity to reflect on internal experience.</td>
</tr>
</tbody>
</table>

### DSMMC ApS College of Clinical Psychologists Conference 2017

**Source:** DSM-5 American Psychiatric Association
DSM-5 NPD Specifiers

Trait & personality functioning specifiers may be used to record additional personality features that may be present in NPD but not required for diagnosis.

For example, other traits of Antagonism (e.g., manipulativeness, deceitfulness, callousness) can be specified when more pervasive antagonistic features (e.g., malignant narcissism) are present.

Other traits of Negative Affectivity (e.g., depressivity, anxiousness) can be specified to record more “vulnerable” presentations.
**PID-5 Long Version**

**Grandiosity**

- To be honest, I am just more important than other people.
- I have outstanding qualities that few others possess.
- I have achieved far more than almost anyone I know.

**Attention-seeking**

- I do things to make sure that people notice me.
- I do things so that people just have to admire me.
- I crave attention.

**PID-5 available in:**

- long & brief versions for adults and adolescents
- informant version for adult only

**Source:** https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures
**TABLE 5.** Reasons people with narcissistic personality disorder often refuse treatment

1. Many people with this condition will not accept that they have any personal problems, much less significant problems with their personality.
2. Many people with this condition are high achievers by conventional measurements, such as job-related prestige and personal wealth. Therefore they and some others who know them do not believe that they have significant problems.
3. The reality of societal stigmatization of people with mental illnesses is an additional impediment to people who wish to be regarded as superior to others.
4. People with this condition are grandiose and like to view themselves as being fiercely independent and not needing the help of others—certainly not of a psychotherapist.
5. Even when people with this personality disorder will acknowledge the need for some help, they do not feel that any therapist is sufficiently intelligent or skilled to treat a person with their special gifts, personal qualities, and qualifications.
6. People with narcissistic personality disorder desire the constant praise and admiration of others, so the thought of having a mental health professional point out their problems and deficiencies would not be appealing.
7. People with this disorder do not tend to pursue in great depth any challenge (such as psychiatric treatment) that by their nature will not garner public attention and admiration.
8. People with narcissistic personality disorder tell lies to enhance their self-esteem. Truthfulness with the therapist is a prerequisite for successful psychiatric treatment.

**Table 4. Patients With NPD in Treatment**

<table>
<thead>
<tr>
<th>Reasons for Seeking Treatment</th>
<th>Problems, Complaints, and Symptoms</th>
<th>Personal Functioning and Life Circumstances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployment or unrealistic</td>
<td>Denial or lack of awareness of personal problems or suffering; unassertive qualities; projection or blame of problems onto others</td>
<td>Consistent self-enhancing or narcissistically sustained functioning; fluctuations in vocational/professional performance or in collaborative or interpersonal functioning</td>
</tr>
<tr>
<td>Disinhibition with life; unable to reach or pursue goals or avoid misfortunes</td>
<td>Absence of major external problems; inner emptiness, meaninglessness, depression, inability to form or maintain close relationships, social isolation, facing limitations or inability to reach goals in personal or professional life</td>
<td>Consistent or high-functioning self-regulatory sustaining interpersonal and/or vocational ability, areas of success, or recognition; internal object, self-criticism, distancing, and detachment</td>
</tr>
<tr>
<td>Acute crisis; vocational, financial, or personal troubles or losses</td>
<td>Hopelessness, suicidal ideation, situational events, insecurity, inferiority, shame, fear</td>
<td>Sudden or gradually developing corrosive life circumstances</td>
</tr>
<tr>
<td>Mental disorder; acute or gradual onset of bipolar disorder, substance abuse (PTSD), or major depression</td>
<td>Depression, anxiety, rage or mood liability, growing dependency on alcohol or drugs, sudden memory flashbacks, or intrusive thoughts</td>
<td>Self-enhancing function of nondestruction or substance use; recurrence of narcissistic trauma; sudden or gradual functional decline</td>
</tr>
<tr>
<td>Suicide; acute serious suicidal preoccupation; having survived a lethal intent suicidal effort</td>
<td>Internal drama, fear, overwhelming shame and humiliation, worthlessness, rage</td>
<td>Job loss, financial crises, failed marriage, divorce, loss of significant attachment or self-regulatory support; other subjectively traumatic or severely humiliating experiences</td>
</tr>
</tbody>
</table>


Narcissists in Therapy

Ronningstam (2014):

- Present as a significant challenge in diagnostic & therapy process:
  - Limited ability to recognise contribution to their problem
  - Limited ability to recognise impact on others
  - Hypersensitivity and defensive reactivity
  - Limited capacity for self-disclosure, self-reflection
  - Limited capacity for empathy

Narcissists in Therapy

Ronningstam & Weinberg (2003):

- Can seek treatment for various reasons & at different life stages.
- Initial contacts - explore relevant problems & willingness to address meaningfully
- Important to identify understanding & description of problems & motivation
- Treatment needs to be flexible, based on individual's:
  - functioning,
  - motivation
  - degree of self-awareness,
- Respectful, consistent, attentive, and task-focused therapeutic attitude.
- Alliance building requires slow & gradual process.
- Central task - balance avoidance & sudden urges to reject therapist & drop out with goal of encouraging & enabling client to face & reflect upon experiences & behavior.
Narcissists in Therapy

Ronningstam & Weinberg (2003):
Common mistakes in treatment:

• directly confronting or criticizing grandiosity
• over-attending to C’s grandiosity by ignoring insecurity, vulnerability and failures, as well as real personal capabilities & assets
• engaging in competitive, controlling relationship with client
• taking passive approach, expecting client will generate necessary solutions & progress without external help.

Awareness of pitfalls helps avoid impasses or early treatment terminations.  

40% will terminate treatment prematurely

Assessment

Irrespective of therapeutic approach want to find out:

• What each parent was like?
• What messages did they give client?
  • What was valued/rewarded?
  • What was not valued/punished?
  • What were rules for parents with respect to client & for others?
  • What was missing or not given?
• How did this make them feel?
Suicide & Narcissistic Clients

Ronningstam & Weinberg (2013):

- Comorbid disorders interact with NPD dynamics to increase suicide risk.
- Some stressful life events increase risk of suicide:
  - Legal or disciplinary problems
  - Unemployment
  - Physical illness
  - Financial problems
  - Work or school problems
  - Aging or age-related losses and transitions
- Why: because challenge narcissistic sense of stability by removing internal or external sources of self-esteem

General Principles

- Validate client’s experience, needs & emotions but seek to alter it (as described later)
- Provide collaborative structure – don’t allow aimless sessions on topic de jour
- Invest them in ownership – must be something working on for selves.
- Use praise or support for their strengths & various approximate steps.
- Impose limit-setting on behaviour – see Behary Schema Therapy articles
- Use their narcissism as a tool in therapy – see Newman & Ratto chapter
- Be aware of transference and countertransference

While individuals with a narcissistic style are often desperate to secure others’ approval, they tend to be oblivious to how others actually view them. Providing feedback typically requires a sensitive, slow, and strengths-based approach, scaffolding critiques & feedback with acknowledgement of the clients’ strengths & virtues. A colleague related the following example: Nearly every week, the patient criticized some aspect of my colleague’s therapy office. One session, however, the patient came in with a partial “fix,” a new and clearly nicer tissue box. My colleague graciously thanked his patient, commenting, “You’re so capable of being kind and helpful but I’m not sure you were aware of how hurtful your criticisms felt to me.”

General Principles

Use praise or support for their strengths & various approximate steps.

• If have initial difficulty monitoring cognitions or reporting observations rather than their interpretations or inferences, reinforce any progress rather than criticising failures.

Impose limit-setting on behaviour:

• This includes fees, schedules, cancellations, between-session calls, emails etc as well as compliance with rules around smoking, touching therapist, anger.
• e.g., client responds disdainfully or patronisingly to therapist & justifies by saying, “Hey, I’m paying you.”
• Therapist: You’re paying for my time, not for the right to treat me disrespectfully.” – emphasises the equal relationship & not there to fulfill all of client’s demands. – adapted from Young et al. (2003). Schema therapy


General Principles

Be aware of their need to be superior, admired, & in control so as to avoid feeling weak, vulnerable, inferior.

Modify language so as to not trigger this:

You are not going to fix deficits, you are going to...?
You are not their therapist, you are....?
The narcissistic client’s sense of specialness complicates the therapeutic relationship. He or she is likely to expect special privileges and exemption from the standard rules followed by others. Sometimes by direct words, or covert deeds, the client will demand special attention. For example:

Mark, a 42-year-old salesman, would come early for sessions, ask for an empty office so that he could make phone calls, and would give the therapist’s secretary xeroxing to do, telling her it was okayed by the therapist. When it was pointed out that the client was impinging on the time of the staff, he responded by asking whether the therapist thought that his work was important. The therapist felt he had been put into the position of “proving” that the client was indeed special to him. This was coupled by the client bringing gifts, coffee, newspapers, and holiday cards to the therapist.

Mr. A. began therapy with a rather involved telephone call to set up an initial consultation. After contacting the therapist, the client said that he could be available on Tuesday at 3 p.m. When informed that that time was not available, the client became irritated and said, “Why must I make myself available only when you think it is best? My time and schedule are just as important as yours.” When he was told that that time belonged to another client, he offered to call the other client and “persuade” him or her that they should come another time. When offered an appointment at 4 p.m., he quickly countered with, “How about 4:30?”

Gabbard (2013) describes 4 common patterns of countertransference in therapy with NPD:

- **Therapist as sounding board** – to enhance self-esteem – speak at rather than to. Defeats T need to be needed.
- **Contempt** – T wants to be loved or admired. NPD devalues in order to feel superior. Elicits T anger, resentment, dread or desire to lash out or try to outcompete. Other T show reaction formation & respond with overly kind & empathic manner.
- **Idealisation of therapist** – bask in reflected glory of idealised therapist. But not motivated in therapy itself.
- **Admiration of client** – high-functioning NPD may produce feelings of envy & admiration in therapist who perceives client as charming & entertaining – T “enjoys the show.” May end as mutual admiration stalemate.
Narcissist in Therapy


Schemas & associated behaviours will be evident:

- Comes late or misses sessions
- “Forgets” to pay for sessions
- Devalues therapy & therapist
- Expects special arrangements
- Feels humiliated to have to talk about problems.
- Believes therapy won’t work or not needed as problem resides in other people.
  - Reluctant to engage in self-evaluation because threatens core negative belief regarding inferiority.
  - Externalises source of distress (it’s others) as protective strategy.
  - If therapist recommends them changing, power struggles & resistance result.

Cognitive Therapy: Change

Freeman’s general principals for personality disorders:

- Ask client, “*Why is this important to deal with?*” Have them convince you of value of change.
- Do chain analysis – step by step analysis of events/ stimuli leading up to & after behaviour or problem to determine where to intervene.
- Ask if have idea of how would like to handle behaviour. *Is there a friend or someone at work they would like to be like? Then, what would you be like in this situation?*
- Come up with set of short, medium and long term goals which realistic, sequential, proximal, well-delineated, within repertoire, agreed to, & valuable.
- Identify problems, define goals, target goals, establish change criteria. What should finished product look like? Client must understand & accept conceptualisation.
Cognitive Therapy: Change

Freeman (workshop, 2009):

- Focus on building collaborative alliance as therapy involves asking narcissistic client to do things:
  - They have difficulty doing — e.g., empathy for others, being collaborative, tolerate frustration
  - Have never had to do
  - Have never learned how to do
  - Do tasks that they believe that they shouldn’t have to do
  - Do tasks that they believe are beneath them
- Aim: Focus on C’s short & long term self-interest to choose most adaptive course of action & to motivate them to take that action

Cognitive Therapy: Change

- Set agenda - maintain focus, structure, boundaries, & train decision-making (prioritising).
- For crisis-prone clients, allocate first 15 minutes of session to deal with this.
- Be prepared to deal with blaming, externalising etc directly.
  e.g.: Client gets angry at suggestion of changing behaviour
  - T: Is it worthwhile use spending time on working out how to make it more possible for you to let people know how you feel without them getting scared?
  - C: “Are you saying it’s my fault?”
  - T: “Are you are hearing me say it’s your fault. Is that what I am saying?”
  e.g. Client blames others.
  - T: “They aren’t here. Can we change them if they are not here?”
  - T: “Anything different you could have done to make point without making her anxious?”
Cognitive Therapy: Change

• If client is resisting acceptance of problem, be direct in gaining motivation & engagement.
  • “Is this something that you would like to work on? Would you like to be in less fights?/ Not losing girlfriends.”
  • If client says, “That would take a miracle”, say, “It is real hard. It may be a miracle but is it something you want to work on?”
  • If client says, “It’s going to be too hard”, say “Maybe it is too hard, we don’t know at this stage. Would you be willing to try?”

Cognitive Therapy: Change

• Frequently ask for feedback.
• Don’t avoid difficult issues (suicide, violence, drugs, etc).
• Take precise notes.
• Take careful note of content, context, style of presentation, and mood.
• Maintain boundaries
Schemas & Personality Disorders

- Beck - core beliefs about self of central importance in conceptualising personality disorder clients.
- Negative beliefs falling into two categories:
  - helplessness (e.g., I am helpless, powerless, inadequate, weak, vulnerable)
  - unlovability (e.g., I am unlovable, unworthy, defective, undesirable).
- As core beliefs painful, develop strategies to cope with or prevent activation:
  - rules (e.g., I must not let others take advantage of me),
  - attitudes (e.g., It would be terrible if others saw me as weak),
  - conditional assumptions (e.g., If others take advantage of me, then it means I’m a thoroughly weak person).

Schemas

- While adaptive as allow highly efficient processing of information, schema can become “hardened” over time such that assimilation occurs more easily than accommodation - so become negatively biased, maladaptive, rigid & self-perpetuating (Dozois & Beck, 2010).
- Maladaptive schemas develop during early childhood & become more consolidated with assimilation of subsequent experiences.
- Poor early attachment experiences & other adverse events predict development of negative belief system.

**Cognitive Therapy: Narcissistic Schemas**

Beneath core beliefs about self & others are reverse beliefs:

**Self** – “I am inferior, a piece of garbage” – activated when perceives others as disregarding or critical

**Others** – “Others are superior, hurtful, demeaning”

**Conditional Assumptions**

- If I act in a superior way, I can feel better about myself (if I don’t I will feel inferior)
- If people treat me in special ways, I can feel superior to them (if they don’t, I should punish them)
Assessment of Core Beliefs


- Measure of dysfunctional beliefs to be associated with specific PDs.
- Aids cognitive conceptualisation in therapy
- Two versions exist:
  - Full Form – 126 items
  - 14 items specifically deal with narcissistic
  - I am a very special person
  - I don’t have to be bound by rules that apply to other people
  - If others don’t respect my status, they should be punished

Assessment of Core Beliefs


- (Beck, Butler, et al., 2001) – good reliability – but NPD also scored high on paranoid PD & OCPD – may reflect intolerance of imperfection, investment in rightness of views, & perceived vulnerability to slights against self-image
- **Short Form – 65 items** – presented in random order
  - (Butler, Beck, & Cohen, 2007) – 7 factors including antisocial/ narcissistic
  - Fournier et al. (2012) – NPD scored highest on this factor
Schemas & Therapeutic Relationship

<table>
<thead>
<tr>
<th>Personality disorder</th>
<th>Fearful view of others/therapist</th>
<th>Overdeveloped strategy</th>
<th>Suggested therapist stance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Passive-aggressive</td>
<td>“They are trying to control me and dump all the work on me.”</td>
<td>Surface agreement and suppressed emotions; indifferent to tasks or results; talks in circles</td>
<td>Empathically negotiate treatment goals; brainstorm or cocreate homework; ask about emotions; designate a task for yourself in homework</td>
</tr>
<tr>
<td>Narcissistic</td>
<td>“They might not recognize how special and superior I am.”</td>
<td>Brags and puts therapist down; focuses on self-aggrandizement; avoids taking responsibility for interpersonal problems; may have “blowups” and focus on blaming others; may terminate early</td>
<td>Allow patient to feel superior, especially initially; empathize with interpersonal difficulties; help patient see why it is to his or her advantage to improve his or her relationships; carefully provide rationale when setting limits; provide complimentary attention to ordinary, prosocial behaviors</td>
</tr>
</tbody>
</table>


Schemas, Narcissists & Therapy

Reframing narcissist’s specific schema patterns in nonperjorative way, can assist therapist in defining, creating & refining therapeutic interventions in such way that client feels understood.

• “You have special needs right now that you feel aren’t being met. Maybe we can work together on some other options to having those needs met.”

Use similar method to motivate engagement in tasks (assessment or homework) normally would resist as reinforces “defectiveness”. Becomes chance to demonstrate prowess.

• “I wouldn’t normally ask a client to do this test/task as most clients cannot do such advanced cognitive therapy work so soon in treatment”
Cog Therapy Schemas, Narcissist & Therapy

• Therapy-Interfering Beliefs
  • If I am not vigilant, my therapist will put me down.
  • If I don’t impress them with my superiority, my therapist will think I’m inferior.
  • If I don’t punish my therapist for making me feel small, she’ll do it again & again.
  • If I don’t push hard, I won’t be treated in a special way.

• Therapy-Interfering Behaviours
  • Trying to impress therapist
  • Demanding entitlements
  • Treating therapist as inferior
  • Punishing therapist if hurt or slighted.
  • Resisting homework assignments


Sam, the surgeon mentioned earlier, came to therapy with great reluctance, as part of marital therapy. He had been married for 42 years to Anita. She had suffered a “nervous breakdown” (Major Depressive Episode), which required hospitalization. The treating resident strongly recommended marital therapy. As part of the assessment, Sam was seen for two sessions. While he made it quite clear that he did not like being in the therapist’s office, he was smiling, pleasant, and collegial. He stated that he did not want to be part of the therapy (“I really don’t think that I can offer anything useful”), was very busy (“You know how it is. We’re all so busy”), and did not think that there was anything wrong with his wife that had anything to do with him (“This is her problem, it always was”). When his pleasant and charming manner did not work to convince the therapist that Sam’s involvement in therapy was unnecessary, he became brusque, bordering on rudeness. “Why,” he inquired, “am I seeing a therapist who is only an associate professor, when I am a full professor? If I have got to be part of this ridiculous business, I might as well have the best person.”

Sam and Anita had been married for 42 years. The primary marital problem revolved around Sam’s demanding that his wife wait on him, hand and foot. She had little more than servant status and was expected to provide for his every whim. She had graduated from college and had immediately gotten married, becoming a housewife and mother. Over the last 10 years, Anita had become more and more “down” and finally ceased functioning and was admitted into the hospital. The beginning of her deterioration coincided with the last child’s marrying and leaving home. Sam’s view of Anita’s problem was that she was just “too moody, too weak, too spoiled, and too reluctant to do her job,” which was, in his eyes, to do his bidding. Sam considered his position in life as one that was well deserved. He described himself as a tyrant in the operating theater because “I’m damn good.” He described, with great relish, how he had his residents and nurses jump whenever he came into a room.

The goal of therapy, within the context of the agreed-upon marital work, was to have Sam respond differently to his wife; the rationale was that this would help Anita return to full functioning. It was pointed out to Sam that if he continued to create stress, his wife would continue to be depressed and would be unavailable to meet his needs. With this as a rationale, he was willing to continue in therapy.
In the treatment of Sam and Anita, marital sessions were held weekly, and Sam was seen individually every other week. The therapy work with Sam was quite limited, with much of the treatment consisting of direct instruction on more adaptive ways to behave with Anita. He did, in fact, alter his response to Anita, not because he agreed with the changes but because if he did not make those alterations, he would get even less of what he wanted.

Anita was a dependent individual who wanted to maintain the marriage. She stated that she loved Sam and understood him “like no one in the whole world does.” The focus of work with Anita was to have her be more assertive and try to refuse doing things that she did not want to do. If Sam wanted certain things done, they could hire someone and pay that person to do it, or Sam could do it himself. After 6 months of therapy, Sam and Anita terminated the therapy. She was less depressed and described Sam as more responsive. She also pointed out that any response on Sam’s part was more response than she had gotten in the past.

Brent, a 35-year-old depressed patient with narcissistic personality disorder, believed that he was basically inferior and that others were superior, though he covered up these beliefs of inferiority with demonstrations of his superiority and entitled demands. He continually believed that others would disrespect him. Small events, even neutral ones, often sent him into a rage: a clerk failed to thank him for payment; an usher pointed out his seat rather than showing him to it; a man in an elevator did not hold the “Open Door” button for him; the manager of a store asked him to leave at closing time.

The same beliefs that became activated in his dealings with others also became activated during treatment itself. Because he was coming to therapy for help, he automatically felt in an inferior position. He assumed his therapist would see herself as superior and him as inferior—and treat him as an inferior. He was hypervigilant for putdowns and misread his therapist’s intentions. He tried to belittle her, making “jokes” about the furniture in her office, asking her if she knew the meaning of arcane psychological terms, acting surprised when she had not heard of his favorite classical music artist, stating that his previous therapists were more skilled than she was. He also acted inappropriately sullen when his therapist did not accede to his requests for special favors such as setting appointments outside of the therapist’s usual hours. Brent tried to impress his therapist with his superiority in various ways: using sophisticated vocabulary, pointing out his high-status clothing, bragging about minor accomplishments at work.

Source:
His therapist conceptualized that if he confronted him about his critical remarks early in treatment, she would probably further activate his beliefs of inferiority. Instead she took pains to react nondefensively. When Brent asserted that she was less skilled than his previous therapists, she asked, “Can you tell me what they did that I don’t do so I can help you more?” When he asked her about a psychological concept with which she was unfamiliar, she said, “I don’t know about that. I probably should, though. What does it refer to?” When he made jokes about the appearance of her office, she laughed with him and made a joke herself: “You know, I knew I should have gotten an MBA. Then I could have had great furniture!”

In this way, the therapist accomplished several therapeutic goals. She directly modeled nondefensive behavior and demonstrated that it is possible to take criticism and put-downs without a diminishment in one’s self-esteem. Failing to criticize or put Brent down decreased his sense of vulnerability and increased his sense of trust in the therapist, thereby strengthening the therapeutic alliance. Over time, after many different kinds of interventions, Brent began to change his beliefs. He felt less and less of a need to use his dysfunctional coping strategies with his therapist. He also began to believe that perhaps not everyone would put him down. He became more willing to try behavioral experiments outside of therapy in which he did not try to diminish other people before they had, in his mind, the opportunity to diminish him first.

Socratic Questioning

Client believed competing successfully against others only measure of success & value as person.

T asked: "Imagine you are to be placed on deserted island, & will never have contact with other people. If you choose, allowed to bring several people, 4 books, some music, some clothes, favorite cuisine (magically prepared exactly way want it), some learning tools (like computer), & four adult toys. What would you bring?"

Patient asked if could bring parents (along with wife), & told could visit as often as wanted. Commented his daily routine would be filled with outdoor activities, reading, & doing things never had time to do.

T asked: Would he envy colleagues on Wall St, working long hours & making lots of money?

C said would pity them. "Don't you already have ingredients for your deserted island—family, friends, culture, and play?" Novel perspective for him—that he already had "enough."


Example: Misty


27 year old medical technician who also participated in beauty pageants.

Came at grandmother’s urging after becoming depressed due to:

- Boyfriend breaking off relationship due to her selfishness & spoilt brat behaviour – M indignant about this.
- Involved in shouting match with chief surgeon bc corrected her behaviour in front of another technician – told she had issues
- Risk of losing license after number of fines & recent collision with police car when drove in emergency lane bc traffic jam due to prior accident – “not about to sit & wait with all those other sheep.”
Example: Misty

- Believed entitled to be spoilt & was indulged by stepfather & supported by mother & grandmother in her pageant competitions.
- Lived rent-free in her grandmother’s house & asked her to give her money for cosmetic procedures, clothes etc
- Grandmother worked part-time as retail salesperson & had advancing arthritis – M believed grandmother “needed” to work to give her money to feel useful & happy.

Source: Beck, Freeman, Davis et al. (2004).
Cognitive therapy of personality disorders (2nd ed). New York: Guilford
Socratic Questioning

T: So your grandmother is irritable in evenings sometimes, especially when you don’t come home for dinner. Be your gran, & tell Misty what’s making you so cranky?

M: I’m tired from work, & stiff from my arthritis. It’s hard to get around, & making dinner is hard. I just want to go to bed.

T: Is it possible she is stressed by working at her age, & you relying on her?

M: Oh, she enjoys spoiling me and making me happy.

T: I’m sure she loves you & does enjoy making you happy. But is it possible that working when she is exhausted, in pain, & needs money for herself might be physically or emotionally harmful?

M: I don’t know; I guess it is possible.

T: Would you be willing to gather some evidence to check this, by asking her about her feelings?

M: I suppose so.

Source: Beck, Freeman, Davis et al. (2004). Cognitive therapy of personality disorders (2nd ed). New York: Guilford

### TABLE 11.3. Possible Beliefs for Building Self-Esteem through Sharing and Belonging

- “One can be human, like everyone else, and still be special.”
- “Self-esteem can come from participating and belonging.”
- “It’s good to do some things just to have fun, build relationships, or contribute to others, without regard for recognition.”
- “I can be ordinary and be happy.”
- “There are rewards in being a team member.”
- “Liking is good enough for me, and that is all I need.”
- “Other people can be resources, not just competitors.”
- “Feedback can be valid and useful, even if it’s uncomfortable.”
- “Everyone is special in some way.”
- “Superiority and inferiority among people are value judgments and thus always subject to change.”
- “I don’t need constant admiration and special status to exist and be happy.”
- “I can enjoy being like others, rather than always having to be better.”
- “Status is the measure of my worth only if I believe that to be true.”
Behavioral Experiment

Misty tested idea, “I don’t always have to feel special to be happy.”
Went to lunch with coworkers & didn’t seek admiration & focused on them.
Saw ex with rising music star – felt worthless as with someone more special
Reviewed adv & disadv of being with him – concluded happier without.
Tested whether could build self-esteem by doing this for fun, or doing things for others.
Drove her gran to visit relatives & joined book discussion group.
Reported enjoyment & surprise others thought well of her bc of simple things anyone could do.


Useful References

  - 3 editions of text. Covers basic principles of adapting CT to personality disorders. First 2 editions have chapters on application to NPD.
  - 3rd edition illustrates schema therapy approach.
Other Useful References


Schema- (Focused) Therapy

SFT is integrative model designed to extend Beck’s original model of CT to specifically address needs of personality disordered clients.

Problems with Beck’s original model -to be successful:

- Clients had to be able to access thoughts & feelings
- Had to have identifiable problems to focus on
- Were motivated & able to do homework
- Engage in a collaborative relationship with therapist
- Cognitions were flexible enough to be modified using Beck’s methods.

Personality-disordered do not meet these conditions.
Schema- (Focused) Therapy

- Integrates cognitive, behavioral, experiential, & interpersonal techniques, utilising concept of a “schema” as unifying elements.
- Adopts traditional cognitive therapy techniques but also uses interpersonal & experiential techniques within cognitive-behavioural framework.

Compared to traditional CT:
- makes > use of therapeutic relationship as vehicle of change
- > extensive discussion of early life experiences & childhood origins of problems.
- > emphasis on affective experience through imagery & role-playing
- relies < on guided discovery & uses more active confrontation of cognitive & behavioural patterns
- longer in duration.

Early Maladaptive Schemas

- Comprised of memories, emotions, cognitions & bodily sensations.
- Defines as “broad, pervasive themes regarding oneself and one’s relationship with others, developed during childhood and elaborated throughout one’s lifetime”.
- Valid representations of early childhood experiences & serve as templates for processing & defining later behaviours, thoughts, feelings, and relationships with others.
- Because develop early in life - habitual & unquestioned, rigid, unconditional & implicit.
- Deeply entrenched patterns central to one’s sense of self. Self-perpetuating & difficult to change using short-term techniques.
Early Maladaptive Schemas

- Capable of generating high levels of disruptive affect, extremely self-defeating consequences &/ or significant harm to others.
- Dysfunctional - interfere with ability to satisfy basic core needs for stability & connection, autonomy, inter-personal relatedness, desirability, & self-expression, or & capacity to accept reasonable limits.
- Schemata start out as an interplay between child’s innate temperament & ongoing aversive experiences with parents, siblings or peers (abuse, neglect, instability, excessive criticism, abandonment, or overprotection).

Coping Styles

- Develop maladaptive coping styles & responses early in life to adapt to schemas & to prevent intense, overwhelming emotions they engender.
- Typically behavioural but can be cognitive & emotional strategies.
- Different people with same schema can show different coping styles or person might use different ones at different times.
- Were usually adaptive in childhood & healthy survival mechanisms but are maladaptive as grows older because serve to perpetuate schema.
Schema Surrender

- Accepts that schema true and do not avoid or fight it
- Act in ways that confirm schema
- Repeat schema-driven patterns (cause them to continually encounter same childhood experiences that created schema)
- Emotional responses disproportionate when schema triggers encountered
- Emotions experienced fully & consciously
- Choose partners who treat them as offending parent did
- Relate to partners in ways that perpetuate schema (e.g., passive, compliant)
- In therapy, may play out schema (client in ‘child’ role & therapist in ‘offending parent’ role)
Schema Avoidance

- Attempt to live as if schema does not exist; arrange life so schema never activated
- Avoid thinking about schema: block thoughts & images that may trigger it (by distracting themselves or putting them out of mind)
- Avoid feeling schema (reflexively pushing them back down)
- Avoid situations that may trigger (e.g., intimate relationships or work challenges). May avoid whole areas of life feel vulnerable in
- When interact with others may appear ‘normal’, but may drink excessively, take drugs, have promiscuous sex, overeat, compulsively clean, seek stimulation or become workaholics
- Often avoid engaging in therapy (e.g., ‘forget’ to complete homework, raise only superficial issues, come late to sessions, avoid expressing affect or terminate prematurely)

Schema Compensation

- Fight schema by thinking, feeling, behaving & relating as if opposite of schema true
- Try to be as different as possible from child were when schema acquired (e.g., if felt worthless - try to be perfect as adult; if abused - abuse others as adult)
- If faced with schema, counterattack (behaviour excessive, insensitive or unproductive)
- Appear self-confident & assured on surface, but feel schema threatening to surface (over-compensators often admired people: media stars, politicians, business tycoons)
- Partially healthy attempt to fight back against schema but ‘overshoots & schema perpetuated. Healthy if proportionate to situation & takes into account other’s feelings
- Develops as alternative to pain of schema: means of escape from sense of vulnerability & helplessness felt as child
Early Maladaptive Schemas In NPD

- emotional deprivation
- defectiveness/Shame
- mistrust/abuse
- failure
- approval-seeking
- unrelenting standards
- entitlement
- insufficient self-control
- may see subjugation, abandonment, punitiveness, & negativity

Schema Modes

- Moment by moment emotional states & coping responses
- “those schemas or schema operations – adaptive or maladaptive – that currently active for individual.” Young, Klosko & Weishaar (2003, p.37)
- Dysfunctional schema modes are activated when life-events activate specific EMS or coping responses which cause emotional reactions, avoidance responses, or self-defeating behaviours that impact on functioning.
- May shift from one dysfunctional mode to another – different set of schemata & coping processed become activated.
- Aim of Schema Mode therapy is to flip or switch maladaptive mode reaction to healthy mode
Schema Mode Therapy

Therapist is model for Healthy Adult mode, client gradually internalises & learns adaptive strategies for healing, integrating or fighting other modes. Goal is for C to be able to:

• Empathise with & protect Abandoned Child
• Help the Abandoned Child to give & receive love.
• Fight against and eliminate the Punitive Parent
• Set limits on behaviour of the Angry & impulsive Child, & help C in this mode to express emotions & needs appropriately.
• Reassure, & gradually replace Detached protector with Healthy Adult

### Schema Modes: Therapist Interventions

<table>
<thead>
<tr>
<th>Schema mode</th>
<th>Unmet childhood needs</th>
<th>Therapist intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vulnerable Child</strong></td>
<td>Secure attachment (includes safety, predictability, stable base, love, nurturance, attention, acceptance, praise, empathy, guidance, protection, validation).</td>
<td>Meet the listed needs, comfort, soothe, reassure, wrap in blanket, connect with vulnerable child (VC) in a concrete way to match developmental level, listen, reassure fears, soft tones.</td>
</tr>
<tr>
<td><strong>Angry Child</strong></td>
<td>Guidance, validation of feelings and needs, realistic limits and self-control. Freedom to express, validation of needs and emotions.</td>
<td>Listen, emotional expression, support venting, guide them into safe anger expression (e.g., tug-of-war), set limits for safety or to prevent negative consequences. Help them identify unmet need they are responding to, understand that they may have difficulty thinking while very angry.</td>
</tr>
<tr>
<td><strong>Impulsive/Undisciplined Child</strong></td>
<td>Realistic limits and self-control, validation of feelings and needs, guidance.</td>
<td>Set gentle yet firm limits, guide, teach healthy release mechanisms. Help them identify the need that is present.</td>
</tr>
<tr>
<td><strong>Happily Undeveloped</strong></td>
<td>Spontaneity and play. Nurturance, attention, validation, acceptance, encouragement to explore and play.</td>
<td>Take pleasure in them and their playfulness and show this visually, smiles, laughter, invite them to play, play with them.</td>
</tr>
</tbody>
</table>
Schema Modes: Therapist Interventions

**Passive Parent**
Restricts, criticizes, and punishes self and others. Harsh, rejecting, all or none in judgments.

**Demanding Parent**
Sets high expectations and level of responsibility for self and sometimes others, pressures self or others to achieve them.

**Avoidant Protector**
Pushes others away, breaks connections, emotional withdrawal, isolates, avoids.

**Overcompensator**
Coping style of control, and control. Sometimes semi-adaptive.

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**Schema Modes: Therapist Interventions**

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Coping style of control and control. Sometimes semi-adaptive.

---

**The Dysfunctional Parent Modes** suppress and reject the needs of the child. This can apply to any need—particularly love, nurturance, praise, acceptance, guidance, validation, emotional expression.

**Stop the Passive Parent Mode (PPM)** message, set limits on and eventually banish this mode.

**Support and connect with the VC needs.**

**Challenge the message, reassess what reasonable standards and expectations are.**

**Support and connect with VC needs.**

**Any unmet childhood need can produce one of these Maladaptive Coping Modes, thus any need can underlie them. They are versions of the survival responses of flight, fight, and freeze and are overused and automatic. The immediate need is connection and empathic confrontation. Long-term need is to learn healthy copings that fit better with adult life. That is the goal of therapy and requires developing the Healthy Adult Mode (HAM).**

**Help patient identify underlying need and evaluate whether the overcompensating style is meeting it. Connect patient with his/her Vulnerable Child Mode (VCM). Limit damage to group.**
**Schema Modes: Therapist Interventions**

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</thead>
<tbody>
<tr>
<td><strong>Compliant Surrender</strong></td>
<td>The Maladaptive Coping Modes need to be reserved for extreme emergencies.</td>
<td>Identify unmet need, evaluate whether coping mode meets it, help get need met. Connect with VCM.</td>
</tr>
<tr>
<td><strong>Health Adult – underdeveloped</strong></td>
<td>Acknowledgment and support of autonomy, competence, sense of identity.</td>
<td>Invite the use of competence in GST, create opportunities to use and recognize strengths and point them out with accurate positive feedback.</td>
</tr>
</tbody>
</table>

Assessment in Schema Therapy

- **Young Schema Questionnaire**
  - YSQ-L3 – Long Version – 232 items – items endorsed 5 or 6
  - YSQ-S3 - Short version – 90 items -5 highest loading items on each EMS

- **Young Parenting Inventory** – 72 items
  - Identification of childhood origins of schemas
  - Rate mothers & fathers separately on behaviours hypothesised to contribute to development of schemas
  - Give few weeks after YSQ
  - With exception of items 1-5 (reversed coded), 5 & 6 items are noted.
  - Explored in detail next session with client giving examples of how parent manifested behaviour.

- **Schema Mode Inventory** –II – 118 items
  - Measures 14 schema modes

Modes & Personality Disorder

- Schema modes viewed along spectrum of dissociative states (Multiple Personality at extreme end & normal shifts in mood at other end)
- Individual in a schema mode is somewhere above middle of spectrum (how far depends on how powerful mode is)
- A mode is part of self that is ‘cut off’ from other aspects of self
- Young proposes Narcissistic PD tend to switch between 3 modes:
  1. Over-compensator (self-aggrandiser)
  2. Vulnerable child (lonely);
  3. Detached Protector (self-soothing)

Narcissistic Personality Example

Over-compensator Mode (subtype “self-aggrandiser” - ‘default’ mode

- Schemas: entitlement, approval-seeking, unrelenting standards, mistrust
- Act superior, status-oriented, entitled and critical or others
- Over-compensate for schemata of defectiveness & emotional deprivation (but perpetuates core schema by alienating others)

Vulnerable (Lonely) Child Mode

- Flip into when cut-off from sources of approval & validation (e.g., receive neg. feedback or criticism)
- Acutely experience a loss of specialness and feels devalued and alone
Narcissistic Personality Example

To escape pain of being ordinary & devalued flip back to ‘self-aggrandiser’ or Detached Protector - function -numb pain of emotional deprivation & defectiveness schemata

• Compulsive stimulation-seeking behaviour may include: gambling, investing, sexual addiction, overeating, drug and alcohol abuse

Goals in Schema Therapy

• Weaken detached protector/self-soother & self-aggrandizer modes so vulnerable child become accessible.
• Once vulnerable child freed from maladaptive coping modes, can be cared for & re-parented, first by therapist & eventually by healthy adult side of personality; & ultimately by others who have chosen to stand by him during treatment.
• In so doing, client learning how to link maladaptive coping modes (that once served to help child to tolerate painful feelings associated with unmet needs) with early experiences & ongoing conditions that trigger these (now) self-defeating life patterns.
• Must learn to drop his guard(s) in order to develop empathy for self & others, and to achieve genuine emotional connection and intimacy with others.

Behary (2011, p. 454)
Core aspects of Schema Therapy & NPD

Presence & maintenance of leverage

• Consistently confront undesirable behaviors, reminding client of consequences does not wish to face if his hurtful interpersonal style & behavioral transgressions continue (e.g., partner leaving, losing job).
• Client must believe there is value in changing even if to avoid losses.

Core aspects of Schema Therapy & NPD

Limited (adaptive) reparenting approach

• harness moment-to-moment, interpersonal (transference & countertransference) experiences relevant to treatment goals, bringing into awareness through use of empathic confrontation & limit-setting
• treatment room microcosm for macro-reality of client.
• e.g. - abiding by rules, allowing others to have turn, respecting boundaries and managing disruptive, aggressive, & demanding behaviors.
• In re-parenting role, help client identify links between dysfunctional behavior patterns & underlying emotional distress - point out moment to moment examples as arise— in therapy relationship & client reports of significant others.
• e.g of limit-setting in therapy relationship - confronting demands for additional time, & other unreasonable expectations that collude with sense of “specialness.”
Core aspects of Schema Therapy & NPD

Limited (adaptive) re-parenting approach

**Empathic confrontation** - offer understanding of client’s feelings & behaviors & how developed in past while holding accountable for adverse effect on him & others.

“I know that you grew up with the message that in order to feel accepted you had to meet certain prescribed standards. You continue to carry forth that theme when you spend a lot of time trying to impress others and dominating conversations. The problem is that it has quality of being overbearing & boorish after a while, & it leaves your friends & associates feeling like an audience instead of participants in a friendly dialogue.”

**Message of empathic confrontation:** It’s not your fault, but is your responsibility to identify and change these habits if you want to have healthy & lasting relationships.

Core aspects of Schema Therapy & NPD

- **Limited (adaptive) re-parenting approach**
  - Relevant self-disclosure used to enhance empathy & attunement.
  - “When you use that tone of voice, with that cynical edge aimed at me, it makes it hard for me care about you. I am trained to understand your makeup, so I am not overwhelmed by it, yet I am aware that I find it off-putting and feel like backing away from you in these moments. I can imagine what it must be like for others who are not clinical professionals—they may just find it offensive and may end up rejecting you.”
  - If calls Therapist “too sensitive”:
    - “Yes, I may be sensitive but I don’t think that would fully explain why most of the people in your life have trouble with this part of your personality. Seems there may be some responsibility on your part that is hard for you to own?”
  - Then proposes that agitation & criticalness could be masking fear or hurt. Goal is to soften edge & get beyond wall to Lonely Child mode.
Core aspects of Schema Therapy & NPD

Emotion-focused and cognitive-behavioral strategies (CBT)

• Persistent efforts to accessing & reparent Lonely Child mode through use of imagery & transformational chair work.
• CBT strategies include audio flashcards, schema diaries, & behavioral role-plays aimed at practice of reciprocity in conversations, expressing emotions & needs, & empathy for others.
• Encouraged to use Healthy Adult mode to meet needs of Lonely Child.
• More able to show vulnerability & (loveable) ordinariness. Learns not have to be in performance mode, proving great, to be accepted.

Schema Therapy, Transference & Countertransference

When patients with NPD do commence treatment, they are often armed with enough arrogance and entitlement to blame not only everyone else for their circumstances, but the therapist as well. And from our experience in countless jam-packed lectures to professional audiences around the world, many therapists report a tendency to have some combination of self-sacrifice, subjugation, defectiveness/shame, emotional deprivation, unrelenting standards, and/or abandonment schemas of their own.

This potentially explains the high attendance at seminars on “Treatment for NPD,” as there are generally few patient populations that can activate a sense of frustration, inadequacy, self-doubt, and intimidation like a narcissist.

Behary, 2011, p. 449
Core Schema Therapy Texts

- Website: [www.schematherapy.com](http://www.schematherapy.com)

Core Schema Therapy Texts

- **Schema Therapy for NPD**
Another Therapy Approach: Metacognitive Interpersonal Therapy


The belief about the importance of appearances will frequently, although not always, extend to those whom the patient views as an extension of him- or herself (e.g., spouse, child): thus the assumption, “My child (spouse) has to make me look good.” Perplexing double binds may arise out of this view for significant others. If they fail to perform in an admirable way (according to the narcissist), they may be ridiculed, punished, or tormented. If they succeed in admirable performance and challenge or surpass the narcissist, they may be ridiculed, punished, or tormented.

Amanda and Lewis arrived at their marital therapy session in a private limousine, courtesy of Amanda’s parents, who always wanted the best for her. Marital tension was focused on Amanda’s growing dissatisfaction with Lewis, and his “unwillingness” to please her. It seems that at 42, his hair was thinning and receding, and he was getting a bit flabby in the middle, although as a sports professional, he remained physically well toned. Slim Amanda proudly pointed out that at size 1, she was the same size as she had been at age 16. Lewis’s unwillingness to please her involved his reluctance to undergo hair implants which, she reasoned, would ensure that he retained some hair as the natural process of thinning progressed. “I just can’t be married to a flabby, bald guy,” she complained. “It would make me look bad.”
Narcissists & Relationships

- Mouilso & Calhoun (2011) – N interacts with willingness to engage in casual sex predicts perpetration of sexual aggression.
Tactics of Narcissist

Plays emotional hot potato
- When raise dismissiveness & lack of connection, responds not dismissive but not willing to respond to anger & constant complaints. Rather than own feelings, projects onto partner.
- Narcissist never wrong, always partner’s fault.
- Partner feels guilty.

Withdraw & attack
- Partner makes demand & narcissist withdraws physically & emotionally—stonewalling, folding arms etc.
- Typically escalates - need unanswered, partner becomes frustrated & louder & narcissist withdraws further. Both parties feel aggrieved & put upon.
- Attacks & blames partner for making demand in first place, casting as sign flawed.

Tactics of Narcissist

Vindictive

• If separating, narcissist will not be open to settling differences or, mediating.
• Will impugn, spread rumors, attack reputation, even if not true.
• Portray self as victim of injustice—not seeking revenge or motivated to win

Indifferent to emotional impact

• Most people want to come out of combative situations losing as few of personal connections & relationships as possible, & feeling behaved fairly
• Narcissist sees destroyed relationships as necessary cost of getting what deserves & if happens to hurt children, then that doesn’t matter.

*Based on Peg Streep (2016) Four behaviours that unmask the hidden narcissist. Psychology Today

Other tactics of narcissistic partner

Rage – intense, furious anger that comes out of nowhere, usually over nothing. Effect: startles & shocks victim into compliance or silence.

Gaslighting – Narcissist lies about past, making victim doubt her memory, perception, & sanity. Claim & give evidence of her past wrong behavior further causing doubt.

The Stare – intense stare with no feeling behind it. Designed to scare victim into submission, Frequently used with silent treatment.

Silent Treatment – Narcissists punish by ignoring. Then let victim “off the hook” by demanding apology even though she isn’t to blame. Aim is to modify her behavior. Will also cut others out of their life permanently over small things.

Projection – Dump their issues onto victim as if she were one doing it. For instance, narcissistic mental abusers may accuse spouse of lying when they have lied. Or they make her feel guilty when he is really guilty. Effect: creates confusion.
Other tactics of narcissistic partner

**Twisting** – When narcissistic spouses confronted, will twist it around to blame victims for actions. Won’t accept responsibility for behavior & insist that victim apologize to them.

**Manipulation** – Narcissist will make spouse fear the worst, such as abandonment, infidelity, or rejection. Then they refute it & ask her for something she normally would reply with “No.” Effect: control tactic to get her to agree to do something she wouldn’t.

**Victim Card** – When all else fails, narcissist resorts to playing victim card. Designed to gain sympathy and further control behavior.

From: Hammond, C.

http://pro.psychcentral.com/exhausted-woman/2015/04/eight-mental-abuse-tactics-narcissists-use-on-spouses/

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Assisting Couples & Partners

Want to assess partner

- What was their family like/ rules / messages
- What were unmet needs?
- What schemas might partner have?
  - Unrelenting standards
  - Self-sacrifice
  - Emotional deprivation/ defectiveness
  - Impaired limits/ entitlement
- Partners may also be narcissistic or dependent
Assisting Couples & Partners

Behary (2013):
Determine their typical response to attack from narcissist

Counterattack – fight – *I’ll show you*

• Effect – escalation or withdrawal by partner
• Change message to – *I have rights too*

• Communicate:
  • Though probably not your intention, I feel devalued by actions & words. I won’t tolerate being treated disrespectfully. I have rights & so do you. I would appreciate it if you could speak to me with more consideration & I will do the same to you.

According to Behary (2013), a partner hurt by narcissist, either through sexual infidelity or typical narcissistic behaviours must asked key questions:

• *Am I committed to staying in the relationship? For what reasons?*
• *Do I feel partner is capable of change?*
• *Do I feel understood about why I am hurt & what my needs are?*
• *Can my partner change so as to express what I need to feel safe enough to trust them again & re-engage in intimacy?*
• *Can I feel safe enough to acknowledge their changes & to recognise and appreciate any signs of empathy, whether solicited or unsolicited?*

Last 3 of these depend on narcissist making clear commitment to change.
Assisting Couples & Partners

Important principle is careful & ongoing evaluation of risk, especially in context of partner having threatened or initiated separation or expressed criticism of NPD partner.

trigger for narcissistic injury - may manifest as rage. Will seek to punish, destroy, humiliate partner.

Extremely important if evidence of malignant narcissism with poor emotional regulation skills and/or a history intmate partner violence. Can display extreme rage to criticism or rejection that threaten self-perception & can be sadistic and aggressive without remorse or empathy.

He or she does not recognize that the partner has rights, feelings, or needs. The person-who-must-be-superior demands special treatment and the partner's complete submission to his or her needs and desires. He or she feels so entitled to get what he or she wants that the partner should feel honored and gratified to give to one so worthy. If the partner denies the person-who-must-be-superior, he or she can respond with threats, intimidating rage, and emotional, physical, and/or sexual abuse. Under such abusive conditions, the partner's thought processes and behavior can become paralyzed by fear. Dangerous and abusive, the person-who-must-be-superior may stop at little to maintain his or her undeserved status - Boldt, 2007, p.148

Narcissism in Workplace

Bill Chang, 41-year-old vice president of manufacturing operations, been promoted over several other managers after only 10 years with company. Colleagues felt Chang's prestigious position came more through office politics & ingratiatation of president than significant personal accomplishment. Although few resentful, most impressed by looks, bearing, charm & achievement. Chang's wife extremely attractive, well positioned in society & mother of 2 beautiful children. Rumoured expensive cars & house & exclusive country club membership paid by wife's family than own income or investments.

Chang's subordinates complained unconcerned about their well-being & their assignments mostly designed to advance Chang's position & he was sacrificing production quality & efficiency for his own short-term benefit. Chang used meetings as platform for grandiose ideas or discussions of personal power, brilliance & future success.

Despite success, hypersensitive to criticism & intolerant of even most constructive advice. Still, Chang had a following. Sought out those in power. Although tolerated subordinates who might be useful to him, had no concern for anyone beneath him. Those feeling appreciated ended up feeling used.
After several months of growing complaints, president realized that some of Chang's character traits been exaggerated by promotion. Besides obvious impairment of departmental enthusiasm & morale, were questions about management style & direction. Shared concerns with Chang & referred him to consulting psychiatrist. Although president figured that Chang needed work on some superficial behaviour, his overall respect for him undiminished. Bill Chang, though, felt rejected & bit humiliated at first. Later, he realized importance of president’s referral. In near term, was able to start paying more deliberate attention to subordinates’ concerns & to long-term planning for his department. Only much later did he start to understand how emotional sensitivity had made him seek admiration as substitute for affection.


**Narcissist in Workplace**

- **Meurs et al (2013)** - grandiose N moderated relship betn interpersonal conflict & counterproductive behaviour to others & organisation
- **Rijsenbilt & Commandeur (2013)** – N associated with CEO fraud

Narcissism in Workplace

Joe, a 33-year-old insurance salesman would take messages out of the mailbox of other salesmen so that he could be the most successful salesman in his office and have his name on the “Salesman of the Month” plaque in the office corridor. When he was caught and was barred from winning for a year, he was incensed that such a big deal was being made of it and that he was not going to get the proper recognition for his work.

James, a 42-year-old male accountant, was referred because of anxiety about his dwindling practice. He would not have anything to do with his clients beyond doing their accounting work because he considered himself above them. He would avoid clients if he met them in a social situation, thinking, “Why should I have to mix with people I consider rabble?” Unfortunately for him, the usual response of his clients was to seek another accountant. The major concern he presented in therapy was that he could not keep up the payments on his Mercedes Benz. His goal was to have the therapist give him ways of responding to his clients so that it would appear that he cared, as long as that did not entail having to have drinks or lunch with them. When the therapist questioned that as a goal of therapy, the client responded by saying, “You are a consultant. I pay you to be whatever I want you to be.”

Suggestions for Helping With Workplace Narcissists

focus on solutions and not problem. Narcissists like to focus on problem & dissect it repeatedly. State problem & quickly move towards solution.

present several solutions. Narcissists like to be in control so provide options. Options make them feel like respect their opinion & asking for them to control process.

be clear. Don’t expect narcissistic boss to provide direction. Will expect others to know what to do, so be clear about objectives before undertaking any tasks. Don’t hesitate to ask.

Protect self psychologically if sense your as an employee is in jeopardy. Recognize may never really be validated in workplace. May do something good without receiving any credit, and it hurts. Normal people may share, narcissists want credit all for themselves

Sources:
### TABLE 5—2. Twenty common characteristics of narcissistic managers

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>They value loyalty in their subordinates more than competence or productivity.</td>
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<tr>
<td>2.</td>
<td>They overestimate their own knowledge about nearly every area of the business or organization.</td>
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<tr>
<td>3.</td>
<td>They do not appreciate the important contributions of others.</td>
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<td>4.</td>
<td>They take personal credit for the accomplishments of others.</td>
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<tr>
<td>5.</td>
<td>They are competitive with and threatened by peers and competent managers.</td>
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<td>6.</td>
<td>They micromanage competent subordinates in areas in which they themselves have little expertise.</td>
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<tr>
<td>7.</td>
<td>They insist on making all decisions—even minor ones—themselves, often with insufficient information about and understanding of the relevant issues.</td>
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<tr>
<td>8.</td>
<td>They overstate their own and the organization’s successes—to the point of bragging.</td>
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<tr>
<td>9.</td>
<td>They never admit to making mistakes.</td>
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<tr>
<td>10.</td>
<td>They blame others for their own mistakes and failures.</td>
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<tr>
<td>11.</td>
<td>They distrust, intimidate, or fire subordinates who make independent decisions or raise concerns about their questionable decisions or business practices.</td>
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<tr>
<td>12.</td>
<td>They surround themselves with “insiders” who constantly praise and never disagree with them.</td>
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<tr>
<td>13.</td>
<td>They do not mentor their subordinates or advance their careers.</td>
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<td>14.</td>
<td>They pursue highly visible (i.e., flashy) short-term successes at the expense of supporting solid, long-range strategic plans.</td>
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<td>15.</td>
<td>They misappropriate the organization’s resources for their personal benefit and self-aggrandizement.</td>
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<tr>
<td>16.</td>
<td>They devalue and underestimate the achievements of competitors in similar businesses or enterprises.</td>
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<tr>
<td>17.</td>
<td>They miss out on important opportunities by not recognizing their own lack of knowledge in some areas.</td>
</tr>
<tr>
<td>18.</td>
<td>They display great deference toward and respect for their superiors to their faces yet criticize, devalue, and undermine them behind their backs.</td>
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<tr>
<td>19.</td>
<td>They respond to constructive criticism of their work with anger, defensiveness, and thoughts or acts of retribution.</td>
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<tr>
<td>20.</td>
<td>They prioritize their own ambitions for advancement over the needs of the organization.</td>
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</tbody>
</table>

TABLE 5–8. Tips for avoiding or dealing with employees or subordinates with narcissistic personality disorder

1. Do your homework before hiring new employees. Call previous employers to ascertain how the candidate for the position performed in past jobs. Ask specific questions about his or her relationships with supervisors. Prevention is the best medicine. If you are in the role of an administrator or supervisor, rereading this chapter may be worth your while.

2. Interview candidates for new positions carefully. Look for the characteristic behavioral and relationship patterns of people with narcissistic personality disorder during the interview. For example, the candidate makes assertions such as “I was indispensable to my previous boss” or “I handled everything in my previous employer’s personal life,” or “The company was a complete mess before I came, but I fixed most of the problems,” or “I left my last job because my efforts and contributions were not appreciated,” your index of suspicion should be heightened. The chances are high that you will be viewed by this person as the next incompetent leader that he or she props up.

3. Do not accept personal favors or special treatment from any employee. You will pay back these favors manifold at the cost of your professional reputation and perhaps your career.

4. Maintain clear boundaries and separations between your vocational and your personal relationships. Personal relationships with subordinates often confuse appropriate vocational lines of authority.

5. Never make a business or personal decision related to any employee that cannot stand the bright light of public scrutiny. If what you are planning to do has to remain a secret, you probably should not be doing it in the first place.

6. Restrict access to confidential information (such as the medical records or salary information of other employees) to experienced personnel with mature personalities and good character. An employee who is inexperienced or immature or whom you believe has a personality or character disorder should not have access to privileged information.

7. Conduct and document regular and judicious performance reviews on all employees and subordinates. Do not include only positive comments; every employee has areas that can benefit from improvement. Beware of employees or subordinates who cannot accept or who overreact to fair and constructive critiques. Such individuals cannot grow on the job and will become underproductive and embittered employees over time.
### TABLE 5—8. Tips for avoiding or dealing with employees or subordinates with narcissistic personality disorder (continued)

8. **Beware of employees who require inordinate praise and demand special entitlements.** No matter how much they contribute to the organization at the time, they are most likely motivated by self-serving ambitions. Ultimately they will be disappointed and destructive workers.

9. **Beware of employees who compete with and devalue their peers (and previous employers).** People with narcissistic personality disorder have difficulties working as team members to achieve organizational goals.

10. **Beware of employees who overstate and overvalue their contributions to the organization.** These individuals often cut corners and make short-sighted decisions to appear better than they are and call attention to themselves.

11. **Beware of employees or subordinates who are not appreciative of or satisfied with fair and generous compensation.** These individuals will ultimately become bitter and are likely to undermine your authority and position.

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