Complexities in Narcissistic Personality Disorder Assessment, Engagement and Treatment

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Tennyson Lee, Ewa Mach, Patrick Grove
DeanCross, Tower Hamlets Personality Disorder Service,
East London Foundation NHS Trust
Overview

Narcissism

Mentalization Based Treatment

Clinical material and responses

Discussion
Different psychoanalytic uses of term

Sexual perversion
  Havelock Ellis: person takes self as sexual object

Stage of development
  Freud

Object relationship
  Rosenfeld, Kohut, Kernberg

Self esteem
A concentration of psychological interest upon the self
Kohut

Deficit in arrest in development of self structure
Deficit in mother’s empathy
  Need for being noticed, approved
  Need to idealise parent and self
Endless search for self object to complete development
Kohut: therapy implications

Permit reconstruction of original selfstrivings
Therapist offers himself as selfobject, allows
  Mirroring TF
  Idealising TF
Empathy > conflict
  eg if patient rages at lack of attention
Need for preinterpretation phase of work
conflict ie faulty development

Pathological self structure:
- Fusion of actual and ideal self and ideal object
- Grandiose self as defence vs rage and envy
- Unacceptable self images projected into external objects

Defensive aim is to
- Maintain self admiration
- Depreciate other
- Avoid dependency
Kernberg: therapy implications

Interpretation to clarify the rage
Link this to yearnings for love of mother
Increase capacity to give up on perfection for intimacy and reality
Figure 1-5. Relationship between familiar prototypical personality types and structural diagnosis.

DSM-IV Criteria for NPD

need 5 or more of following:

1. Grandiose sense of self importance.
2. Fantasies of success/power.
3. Believes self to be special and unique.
4. Requires excessive admiration.
5. Entitlement.
6. Interpersonally exploitative.
7. Lacks empathy.
8. Envious of others.
9. arrogant, haughty behaviors / attitudes.
Only a partial capture viz
thick vs thin skinned (Rosenfeld)
oblivious vs hypervigilant (Gabbard)

<table>
<thead>
<tr>
<th>Oblivious</th>
<th>Hypervigilant</th>
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<tbody>
<tr>
<td>• No awareness</td>
<td>• Highly sensitive</td>
</tr>
<tr>
<td>• Arrogant and aggressive</td>
<td>• Inhibited, shy, self effacing</td>
</tr>
<tr>
<td>• Self absorbed</td>
<td>• Directs attention out</td>
</tr>
<tr>
<td>• Has a ‘sender but no receiver’</td>
<td>• Listens out for slights,</td>
</tr>
<tr>
<td>• Apparently impervious to</td>
<td>criticisms</td>
</tr>
<tr>
<td>having feelings hurt by others</td>
<td>• Easily hurt</td>
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The essential features of a personality disorder are impairments in personality (self and interpersonal) functioning and the presence of pathological personality traits. To diagnose narcissistic personality disorder, the following criteria must be met:

A. Significant impairments in **personality functioning** manifest by:
   1. Impairments in **self functioning** (a or b):
      a. **Identity**: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal may be inflated or deflated, or vacillate between extremes; emotional regulation mirrors fluctuations in self-esteem.
      
      b. **Self-direction**: Goal-setting is based on gaining approval from others; personal standards are unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.
2. Impairments in **interpersonal functioning** (a or b):
   
   a. **Empathy**: Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimate of own effect on others.
   
   b. **Intimacy**: Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others’ experiences and predominance of a need for personal gain.
B. Pathological **personality traits** in the following domain:

1. **Antagonism**, characterized by:
   
   a. **Grandiosity**: Feelings of entitlement, either overt or covert; self-centeredness; firmly holding to the belief that one is better than others; condescending toward others.
   
   b. **Attention seeking**: Excessive attempts to attract and be the focus of the attention of others; admiration seeking.

C. The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time and consistent across situations.

D. The impairments in personality functioning and the individual’s personality trait expression are not better understood as normative for the individual’s developmental stage or socio-cultural environment.

E. The impairments in personality functioning and the individual’s personality trait expression are not solely due to the direct physiological effects of a substance (e.g., a drug of abuse, medication) or a general medical condition (e.g., severe head trauma).
Overview

Narcissism

Mentalisation-Based Treatment

Clinical material and responses

Discussion
Mentalization

How to make sense of yourself and others
  Recognition of one’s own and other’s mental states
  Recognition that what is in the mind is in the mind

Function of prefrontal cortex, acts as buffer when aroused

Fragile Mentalization in BPD patients
Failed mentalization: cause and effect

- Poor attachment
- Trauma
- Teleological stance
- Psychic equivalence
- Pretend mode
Implications for Mentalization based treatment (MBT) in context of an attached relationship

- Giving patient the experience of being mentalized
- Giving patient the opportunity to mentalize

Therapeutic stance

Steps

Mentalizing the transference
Therapist stance in MBT

overall aim: stimulate mentalizing (> insight)

active
empathic
not knowing
non defensive
Steps in MBT

Support
Clarification, challenge, stop and stand
  Define interpersonal context
  Identify if in non mentalizing mode:
    psychic equivalence, pretend mode, teleological stance
  Affect elaboration
Basic mentalizing
  Stop, rewind, explore
  Transference tracers
Interpretive mentalizing
Mentalising the transference
Mentalizing the transference

Validation of transference
Exploration of transference
Accept enactment
Collaboration at arriving at interpretation
Alternative perspective from therapist
Monitor patient’s reaction to the interpretation
Interpret patient’s reaction to the interpretation
Overview

Narcissism

Mentalisation-Based Treatment

Clinical material and responses
   Passivity
   lack of attachment
   antagonism
   thin and thick skinned

Discussion
Clinical material

Passivity
lack of attachment
antagonism
thin and thick skinned
Clinical eg 1

the woman who wants to do it all herself
Presentation in the programme

High sensitivity / wish to control others’ perception of her

Antagonism / withholding or being dismissive in the sessions

Sense of entitlement

Grandiose fantasies
Mentalizing difficulties

Pseudomentalizing

Extensive knowledge of thoughts and feelings of others not necessarily based on evidence

overactive

Pretend mode

Little affect present or expressed in session

Psychic equivalence

Inflexible
Video session
Treatment

Therapist stance
active, empathic, not knowing, non defensive, aim: to stimulate mentalizing

Attention to exquisite sensitivity
graded work: 1st half of programme ‘to be understood’ before ‘to understand’, therapist centred interpretations

Addressing the psychic retreat
contract, life outside DeanCross

Supervision: attention to the countertransference

Use of the team
Using Psychodrama techniques in working with narcissistic patients
Clinical eg 2

the man who gets lost in his own thinking
What is Psychodrama?
What is Doubling?
Session
Lack of attachment
Clinical eg 3
the man who ran too fast
Brief Structured MBT

Objective
   Learn mentalizing approach
to main current difficulty with relationship focus

Approach
   Psychoeducative
   Practical
   Active (CAT, CBT)
      Therapist
      Patient
   Standalone: a short intervention and an assessment

Structure
   ‘6+2’
   Fortnightly ie 4 months
   Clear frame eg re missed sessions
## Brief Structured MBT

<table>
<thead>
<tr>
<th>Phase</th>
<th>Session</th>
<th>Objective</th>
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</thead>
<tbody>
<tr>
<td>Business meeting</td>
<td>Business meeting</td>
<td>Clarify structure</td>
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<tr>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Mentalisation file</td>
</tr>
<tr>
<td>Phase 1</td>
<td>2</td>
<td>Objectives of Rx</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mentalisation file</td>
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<tr>
<td></td>
<td>3</td>
<td>Mentalisation letter</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Id focus</td>
</tr>
<tr>
<td>Phase 2</td>
<td>4,5,6</td>
<td>Work on focus</td>
</tr>
<tr>
<td>End session</td>
<td>7</td>
<td>Ending letter of therapist</td>
</tr>
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<td></td>
<td></td>
<td>Ending letter of patient</td>
</tr>
<tr>
<td>Final meeting</td>
<td>8</td>
<td>Review of Rx</td>
</tr>
</tbody>
</table>
What happened?

Themes addressed
control: shame
feedback

Therapist goodbye letter
Took risks, allowed exploration of relationship

Patient goodbye letter
Denial of feelings
realised I wasn’t quite in the room

Went onto programme
What may have helped

Passivity
  Clarity of frame
  Input of patient

Antagonism
  Tuning into the programme

Sensivity
  Working out the soft spots

Kohut:
  Empathy > conflict
  Allowed mirroring and idealizing TF
  Need for preinterpretation phase of work

Attachment: Relationship with the therapist
  Did develop
  Dx of patient BPD and N
Passivity
treatment contract

Obstacles to Transference Focused Psychotherapy with Narcissistic Patients

Patient’s defensive grandiosity often leads to:
  • A retreat from life’s challenges.
  • Feeling exempt from demands or obligations.
  • A cavalier attitude toward treatment (why submit?).

Importance of addressing secondary gain:
  • Patient may depend on social services or family.
  • “Can not” vs “will not” function.

Managing suicidality / self-injury
Contracting

Objectives of treatment contract

Sets treatment frame
Define responsibility of patient and service
Assesses if patient motivated to pursue Rx at DC

Where fits into programme

After assessment
Needs sign off before Rx

Guiding principle

Allow service to remain neutral and think clearly
Limit patient’s 2ndry gains

Treatment Contract: Patient responsibilities

12 itemised points wrto treatment hierarchy

Safety:
  DSH or other destructive acts (incl passivity)
  Crisis plan
Frame
  Contact, attendance,
Emotional importance
  Openness
    Silence, withholding, lying
Treatment Contract:
Service responsibilities

Safe setting
Stable environment
Advance notice re any changes to the programme
Try help the patient gain cognitive and emotional understanding
Clarify the limits of the service’s involvement
Contracting: experience

• Individual meetings

• Group meetings
  ‘boring’ to ‘can see the point’
  ‘its obvious’
  Use of both contempt and of group norm
  Small things elicit big things: the brother who brings
Antagonism

Staff

Countertransference

  Seduced
  Bored, indifference*
  Defensive

Patients

  Similar
Overview

Narcissism

Mentalisation-Based Treatment

Clinical material and responses

Discussion
A summary of modifications

Passivity: contracting

Attachment: Brief structured individual treatment

Sensitivity and adherence to grandiose self
  MBT: pseudomentalising
  Psychodrama: doubling
  Therapist centred interpretations
  Graded work: 1st half of programme ‘to be understood’ before ‘to understand’

Antagonism
  Supervision: attention to the CTF
FIGURE 1–5. Relationship between familiar prototypical personality types and structural diagnosis.

Postscript: the man who ran too fast

Work

Destructive behaviour

Relationships
Postscript:
the woman who wants to do it all herself

? 
A woman in a parallel universe
Review using treatment contract