

TOWARDS A PSYCHOTHERAPEUTIC GUIDE TO NARCISSISM

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Abstract

Currently, treatment modalities for narcissistic personality disorder are limited in both availability and effectiveness. There is no distinct psychotherapeutic guideline for narcissistic personality disorder and no unified recommendation of psychotherapies and techniques that can be used. This article aims, on the one hand, to present some general recommendations in narcissism psychotherapy, found in the specialized literature, and on the other hand - to particularize on a clinical case some techniques that do not belong to a particular therapeutic orientation, but that have proven their effectiveness in working with this type of clients. The final aim of the whole endeavor is to identify the first milestones/frameworks of a future psychotherapeutic guide for narcissistic personality disorder, useful for clinical psychologists and psychotherapists, aiming at: decreasing self-inflation, decreasing the degree of egocentricity, increasing the degree of empathy and reducing the level of preoccupation with building a grandiose self-image.

Cuvinte-cheie: tulburări de personalitate, narcisism, psihoterapie, ghid, obiective terapeutice..

Keywords: personality disorders, narcissism, psychotherapy, guide, therapeutic objective.

1. INTRODUCTION

Narcissistic personality disorder is a pervasive pattern of grandiosity, a need for admiration, a lack of empathy, and an increased sense of personal importance that persists over a long period of time in a variety of situations or social contexts and can lead to significant impairment in social and occupational functioning (American Psychiatric Association, 2013). The prevalence of narcissistic personality disorder has been estimated between 0.6 and 6.2% of the general population (American Psychiatric Association, 2013) or between 2.3 and 35.7% in the clinical population (Torgersen, 2012).

The scientific literature reveals that narcissism remains one of the least studied personality disorders (Russ, Shedler, Bradley, & Westen, 2008), and this may be related not only to the difficulties in diagnosing it, but also to the complexity of subtypes found within it.

Treatment modalities for Narcissistic Personality Disorder are also limited in both availability and effectiveness – there is currently no separate psychotherapeutic guideline for Narcissistic Personality Disorder. Although European treatment guidelines for personality disorders include psychotherapy as the treatment of first choice, these guidelines focus on borderline personality

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disorder, with a higher frequency in psychiatric clinics and psychotherapists' offices. On the other hand, research findings on the treatment of personality disorders also raise similar issues – again, most studies focus on borderline personality disorder, while other disorders are under-addressed (Bateman et al., 2015)

Simonsen *et al.* (2019) summarized the most important clarifications of European treatment guidelines for personality disorders in general (Sweden – 2017, Germany – 2009, The Netherlands – 2008) and highlighted the functionality across personality disorders of mentalization-based psychotherapy (MBT), behavior-dialectical psychotherapy (DBT), transference-focused psychotherapy (TFP) and schema therapy (ST). The Swedish guideline revealed that treatment of personality syndromes may involve multidisciplinary teams and multimodal programs. It was also found that there is insufficient empirical support for the choice between short-term and long-term psychotherapies. The German and Dutch guidelines showed that treatment with psychotherapy has been shown to be cost-effectively comparable to drug treatment. An attempt to structure the most suitable psychotherapies for personality disorders was made by Weinberg and Ronningstam (2020), and another – by Thomaes and Bushman (2011), in both cases finding techniques belonging to MBT, DBT, TFP and ST.

Starting from this theoretical and methodological deficit regarding the approach to narcissistic personality disorder, the aim of this paper was to highlight the recommendations of the specialized literature in narcissism psychotherapy, which do not take into account a particular therapeutic orientation, but rather bring together techniques that have proven their effectiveness in working with this type of clients.

First of all, any psychotherapeutic approach starts with a good knowledge of the characteristics of the clients, in this case those with narcissistic personality disorder. Thus, clinical narcissism is defined around the idea of grandiosity, and from this perspective it can be considered an extreme form of grandiose narcissism (Miller *et al.*, 2014; Pincus & Lukowitsky, 2010). The diagnosis of narcissistic personality disorder, however, does not take into account the vulnerability that may accompany an extreme grandiose presentation, although outward grandiosity may be merely a facade or mask under which a fragile self is hidden (Akhtar, 1989). Likewise, excessive self-centeredness does not necessarily indicate deficiencies in understanding others, but may highlight a low interest in developing skills in understanding others (Baskin-Sommers, Krusemark, & Ronningstam, 2014; Bilotta *et al.*, 2018; Marissen, Deen, & Franken, 2012; Ritter *et al.*, 2011). In terms of interpersonal relationships, grandiose narcissists can be highly socially skillful, being perceived as charismatic, confident, and extroverted (Jauk *et al.*, 2016). Their difficulties manifest themselves in long-term relationships, especially romantic relationships, due to antagonistic aspects such as self-centeredness and low levels of empathy (Wurst *et al.*, 2017).

Vulnerable narcissism is manifested by traits such as anxiety, defensive and avoidant tendencies, linked to a pronounced self-consciousness (Hart, Adams, Burton, & Tortoriello, 2017; Miller, Price, Gentile, Lynam, & Campbell, 2012). Like grandiose narcissists, vulnerable narcissists focus excessively on self-importance (Krizan & Herlache, 2018; Miller *et al.*, 2016), but unlike the former, they have a negative view of the future (Kaufman, Weiss, Miller, & Campbell, 2020). In the intrapersonal space, vulnerable narcissists exhibit increased neuroticism and introversion, generally experiencing lower life satisfaction and

developing internalizing symptoms such as anxiety and depression (Jauk, Weigle, Lehmann, Benedek, & Neubauer, 2017; Miller *et al.*, 2016).

2. NARCISSISTIC CLIENT APPROACH

The psychotherapeutic approach with the narcissistic person starts with a rigorous assessment, which involves: a clinical interview, the administration of questionnaires and knowledge of his or her life history. Several instruments can be used in the assessment, and it is very important that they are validated and adapted to the population of the country concerned. Among the structured and semi-structured interviews used in the assessment of personality disorders, SCID-II - Structured Clinical Interview for DSM-V Axis II (First, Williams, Smith Benjamin, & Spitzer, 2017), with 140 items, is available in Romania. Another instrument is the OMNI - IV - Personality Disorders Inventory (Loranger, 2016), a 210-item, 10-scale, self-administered questionnaire that measures personality disorders in accordance with DSM-IV criteria. Other instruments to assess personality psychopathology are the MCMI – III Millon Clinical Multiaxial Inventory III (Millon, Davis, & Millon, 1997), the DAPP-BQ Dimensional Assessment of Personality Pathology – Basic Questionnaire (W. J. Livesley & Jackson, 2002), MMPI – 2 Minnesota Multiphasic Personality Inventory (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989) and PAI Personality Assessment Inventory (Morey, 2007).

Next steps in psychotherapy setting therapeutic goals and building an optimal therapeutic relationship. Setting SMART (Specific, Measurable, Attainable, Attainable, Attainable, Achievable, and Time-bound) goals that target a specific change that the client wants to make is essential. Low frustration tolerance, oversensitivity to what narcissists perceive as criticism, humiliation, or shame (Smith, Bouras, Frazier *et al.*, 2024) increase the risk of drop-out, as well as avoidance, both in the general interpersonal setting and in the therapeutic relationship (Gülüm, 2018). Especially when these clients do not come to therapy voluntarily (but are referred or coerced), it is important that therapeutic goals are reframed, centered on a goal that is meaningful to them: "You are coming because you want to not lose X" or "What is one thing you could change so that you don't lose X?".

Establishing clear contracts early on in psychotherapy prevents threats from narcissists (Weinberg and Ronningstam, 2020). Contracts protect the therapeutic alliance itself; they address the most appropriate ways to deal with key moments and behaviors that might interfere with treatment.

Psychoeducation is another key point in building a good therapeutic relationship and maintaining commitment to goals (Cummings & Cummings, 2008). As people who always want to be in control, narcissists need to understand what is going on in therapy in order to tolerate the discomfort of change. How this psychoeducation is delivered towards narcissists with a high degree of arrogance is also important. Explanations should start from what these individuals already know (Ronningstam, 2012). Then, through questions and Socratic dialog, they will be guided to discover for themselves the connections between various elements.

In principle, the psychotherapeutic focus will be on uncovering maladaptive coping mechanisms, how they have been constructed and maintained, and especially how they prevent the narcissist from achieving his goals or satisfying his basic emotional needs that cause him distress (Behary, 2022). Coping

mechanisms will be addressed both cognitively, through Socratic dialog and counter-argumentation, and experientially, through role-playing and imagery exercises. Experiential exercises link cognitive and emotional understanding, permeabilizing the narcissistic defense system (Rafaeli, Bernstein, Young, 2010).

In order to maintain a good therapeutic relationship, especially in difficult moments of psychotherapy, it is necessary that the psychotherapist gives a lot of validation to the real qualities, achievements, skills and progress made. Constant encouragement will help to prevent intensifying the feelings of fear and loss of image/status that come with change. They will also combat procrastination/avoidance tendencies, fears of closeness and loss of hope (Kealy, Goodman, Rasmussen, Rasmussen, Weideman, Ogrodniczuk, 2017).

When narcissists feel threatened, or when they see personal sensitivities approaching, they become angry, mocking, dismissive or even insulting to the psychotherapist. It is important for the psychotherapist to cultivate an atmosphere of calm and patience and to work with themselves to remind themselves not to take the client's remarks personally, but to treat them as signs of touching sensitive points. Because of overcompensatory coping, manifested sometimes in arrogance, sometimes in anger, narcissistic clients generally do not receive real feedback in their relationships or it is provided in a way that does not contribute to change, but instead activates their maladaptive coping and schemas (Wendy Behary & Dieckmann, 2012).

Experiential exercises (imagery for rescripting, mode dialog technique) also help to decrease self-inflation and the degree of egocentricity (Thomaes & Bushman, 2011), building a more compassionate and caring (Malkin, 2016) perspective of self, which ultimately lead to emerging from the risk of narcissistic decompensation. The use of humor to reduce tension, throwing "baits" to clients and letting them catch them, without insistence, are part of the "dance" of therapy.

Particular attention should be paid to countertransference, the main cause of difficulties encountered in therapy and therapeutic failures (Tanzilli, Muzi, Ronningstam, Lingardi, 2017). Psychotherapists' reactions to narcissists are generally intense and varied – anger, fear, tension, boredom or excessive affection. Resolving them can be done by turning to supervision or a permanent intervision group, where psychotherapists can talk about their most difficult cases and receive peer support.

In the office, during the sessions, it is important for professionals to work with themselves in order not to take things personally, to understand their intense emotions (which appear as the acting out of internal dynamics of the clients), but which can bring valuable information to the therapeutic process (Young, Klosko, Weishaar, 2006).

It is precisely the psychotherapist's emotions that can shape new ways for clients to react that are different from the maladaptive ones they generally use. It is also advisable for psychotherapists to avoid power struggles with narcissists, as well as engaging in subjugated or extra-empathic attitudes towards them (e.g. unbounded understanding of grandiosity and entitlement). Healthy boundary setting and benevolent attitudes, therapist expression of prosocial, desirable behaviors and optimal ways of relating can be valuable lessons for narcissists.

3. A CLINICAL CASE PRESENTATION

In order to particularize a set of techniques that do not belong to a particular psychotherapeutic orientation, but which have proven their effectiveness in working with this type of clients, a clinical case from our own practice will be presented below.

Client R.N., 53, married with two children, a lawyer, came to psychotherapy because his wife threatened to divorce him if he did not solve his psychological problems. The marital difficulties arose with the client's wife's professional growth. She began to criticize his behavior towards herself and the children, which he did not understand; he considered these grievances exaggerated. A year before the therapy, R.N. had had a stroke which had left him incapacitated for some time, leaving his wife to manage the house, the lawyer firm and the children. At the time of therapy, he was almost fully recovered from the stroke, with mild feelings of chronic fatigability on waking.

R.N. was the oldest sibling in a family of four children. His parents, both lawyers, art and classical music lovers, had raised him with strict rules of etiquette, both socially and at home. From an early age, his parents did not let him call them *Mom* and *Dad*, but *Mr.* and *Mrs.*, to treat them with respect. He described his parents as his idols – very fair, cultured, extremely smart and professionally accomplished. He claimed to have had a very happy childhood. He enjoyed learning and always being the best, excelling in everything he did: school, sports, extra-curricular competitions, relationships with girls and friendships. In school, he was the most popular kid, both with boys and girls. Law school had been "*a purely personal choice*". Basically, he described everything he had ever done as "*from the very best upwards*".

Diagnosis of the disorder

R.N.'s OMNI-IV Personality Disorder Inventory results indicated a comorbidity between narcissistic and histrionic personality disorder. He could be characterized as reserved, critical, conceited, arrogant, with a manifest desire to be recognized for his merits and worth. Poor empath, even to the point of emotional indifference. There were also detected features of interpersonal hypervigilance in the paranoid sphere – suspiciousness, tendency to misinterpret remarks, sarcasm, and some borderline traits of hypervigilance, but without clinical intensity.

Psychotherapeutic challenges

Psychotherapy lasted about 2 years, with some interruptions. When addressing a vulnerable area, he would state that he was very busy and would not come to the next sessions. Most of the time, it would take between 2 and 4 weeks for him to return to therapy, and then he would act as if nothing had happened, avoiding discussing things where they had left off.

When engaging in therapy, he had no intrinsic motivation for change - rather, he was in a zone of detachment from his wife's emotional needs. He would

have liked his wife's wishes to change, but realized, after much arguing, that she was holding firm to her position. He had, for this reason, reached a helpless rage that expressed itself in either overcompensatory coping or submissive surrender coping to avoid her leaving him. That's why he had shown himself willing "*to change some things until his wife returns to better feelings and realizes she is wrong*".

Since the onset of psychotherapy it was noted that he adopted a mode of overcompensation, more precisely infatuation and hypercontrol, whereby he tried to get what he wanted and on this basis he considered himself entitled to be left alone to do what he pleased. R. N. claimed that he was more intelligent than others, more accomplished and had proved himself better than others throughout his life.

Psychotherapeutic objectives included: building a psychotherapeutic relationship based on trust and mutual respect; exploring dysfunctional interpersonal patterns in family relationships and discovering/implementing more effective relationship strategies; decreasing maladaptive coping patterns by reducing self-inflation and self-centeredness; decreasing the intensity of the feeling of vulnerability to illness by reducing anxiety levels.

The origins of the client's sense of grandiosity were identified in the client's life history: it had been taken from his family through modeling and had made him not allow himself to be anything other than the best. *Discussing* this helped him realize the pressure he had felt as a child. This was followed by *analyzing the advantages and disadvantages* of overcompensation coping. By using *experiential techniques* (mode dialog), he was able to become more aware of the occurrence of these mechanisms even before they were enacted and voluntarily practiced to reduce the frequency and intensity of their manifestations.

He began to differentiate between the voluntary – and appropriate at the time – use of coping strategies, and the automatic emergence of maladaptive coping patterns that prevented him from meeting his therapeutic needs and goals. He realized that overcompensating had helped him greatly, in school and at work, to perform well and achieve well above average accomplishments, and had also ensured his great financial success. The only vulnerability from which to build intrinsic motivation for therapy was his stroke. It had not only frightened him, it had also put him in touch with vulnerability, with his own physical limitations and especially with his lack of control over important aspects of life.

In discussing how he experienced both his disabling medical condition and his recovery from it, the client genuinely expressed fear and wished that such accidents would never happen again. Exploring the potential psychological causes of the stroke helped him to speak out. He recognized the permanent stress he was under in order to maintain his professional and financial status. Talking about the long hours at work, the limited time with his family, as well as the impossibility to have more quality time, he began to realize that he did not have the perfect life he had imagined.

Recognizing his overcompensation coping patterns and the impact they had on his life and relationships, but especially on his own health, led him to enter a new phase of the psychotherapeutic process: getting in touch with his own vulnerability.

After overcoming maladaptive coping patterns, R.N. realized that the way his parents excluded all that was childish, defining these things as *nonsense*, had prevented him from enjoying life and meaningful emotional connections. True, he had formed relationships based on the validation of his performance, but he had

found it hard to allow himself to be loved, cared for and accepted for who he was. It was difficult for him to accept – and to be able to have – close relationships with people who did not admire him, but whom he also understood, with their needs and vulnerabilities.

These realizations were important turning points in the therapeutic process. Subsequently, R.N. was able to set limits in his relationship with his own parents, he was able to see them as human beings subject to mistakes and he became less demanding with himself and others. By lowering his expectations of others, he became less critical and more able to connect with them in a real way. He began to play more with his own children and to genuinely enjoy his wife's success. He asked her out on romantic dates, which had not happened in their relationship for a long time.

Self-regulation and fear tempering exercises helped him to prevent entering maladaptive coping.

Assessment and prognosis

Post-therapy OMNI-IV testing revealed a lower score on the narcissism scale, with the client recording a raw score of 35.1, down from 44.2 ($p = 0.05$, Wilcoxon paired samples test). This score indicated that the client was no longer within the clinical score for narcissistic personality at the time of therapy. On the other hand, according to the change stability index of 2.5, he had made a reliable change.

His infatuation and entitlement mode continued to make him quite isolated in relation to friends. Vulnerability in his relationships with others still aroused in him a sense of shame, which he believed he would resolve some day. In terms of the prognosis in this case, a potential danger may come in the wife's moments of disconnection and emotional deprivation. This was discussed in psychotherapy, and the client developed and practiced various *functional coping strategies to deal with the risk*.

This client's tendency in coping with difficulties was to use maladaptive coping mechanisms. The relationship with his parents had particular implications for the development of his early maladaptive schemas.

The predominant presence of overcompensation coping modes, as well as the grandiosity schema (manifested when the psychotherapist was trying to access her vulnerability), are likely to provoke the psychotherapist's dysfunctional patterns and modes. These challenges can give rise to a problematic relational dynamic, with negative impact on the therapeutic process (Semeniuc, Sterie *et al.*, 2023). Therefore, it is important for psychotherapists to be aware of this possibility (Sterie, 2024).

The use of empathic confrontation (Wendy Behary, 2012) of coping modes and secondary schemas have proved useful both in shaping the therapeutic relationship (increasing therapist authenticity, targeting the distrust schema) and in the process of change. They contributed significantly to the client's awareness and to changing the relational dynamics to which he was accustomed.

4. OUTLINE OF A PSYCHOTHERAPEUTIC GUIDE FOR NARCISSISTIC PERSONALITY DISORDER

In a psychotherapeutic guide for Narcissistic Personality Disorder, goals might include: O 1. Decrease self inflation; O 2. Decreasing self-centeredness and increasing empathy; and O3. Decreasing preoccupation with building a grandiose self-image.

In the case of *O1. Decreasing self inflation*, the model that could be used is to address the maladaptive schemas and coping associated with narcissism.

For *O 2. Decrease the degree of egocentrism and increase the degree of empathy*, targets in which it is necessary to increase the mentalizing capacity, experiential techniques and affective bridges can be used to create links between the cognitive-emotional and behavioral levels. The use of indirect techniques such as therapeutic storytelling, metaphors, anecdotes and humor to target and reframe feelings of shame and inadequacy is also recommended.

In the case of *O 3. Reducing the level of preoccupation in order to build a grandiose self-image*, exercises to gain feelings of personal control and efficacy, accompanied by validation of successes, taking responsibility, using active listening and a collaborative relationship are appropriate. Confronting self-critical messages and increasing insight for intrapsychic processes (understanding triggers, interpretations and coping strategies used) can be used together with empathic accompaniment in moments of vulnerability to rescript childhood experiences.

In the case of *O1. Decreasing self-inflation*, explanatory introspection techniques could be used, aimed at explaining one's own thoughts and feelings. For *O 2. Decreasing the degree of self-centeredness and increasing the degree of empathy*, it is appropriate to activate the orientation towards others and the degree of connection felt with them, and in the case of *O 3. Reducing the level of preoccupation to build a grandiose self-image*, the use of mindfulness techniques and reducing the sensitivity to ego-threatening experiences are applicable.

4.1. TAILORED INTERVENTIONS

Putting one's own characteristics into perspective and questioning why a person is the way they are an example of an intervention adapted for *O1. Decreasing self inflation*.

For *O 2. Decreasing self-centeredness and increasing empathy*, tailored interventions could target: mindfulness training focused on compassion; actively looking for shared characteristics/expressions between therapist and client to emphasize what creates connection; actively looking for shared experiences between client and people with whom the client has difficulties; participating in group therapy and finding shared stories and similarities with other group members. Similar case narratives and materials using indirect techniques to activate self-compassion and reduce feelings of shame is another example of an intervention adapted for O 2.

In the case of *O 3. Reducing the level of preoccupation to construct a grandiose self-image* one could use the construction of exercises that support self-affirmation, consistent with the presence of the social affirmation and recognition/dissociability seeking schema in narcissists. Thus, narcissists can be supported and encouraged to begin the session by telling about the things they are

proud of (serves relationship building). The focus would in this way be on their core values and how these are used in the pursuit of their own goals. Empathic confrontation, which involves both pointing out dysfunctional or self-sabotaging behaviors and offering insight into how they were formed and relevant in the past, is also appropriate in this context.

5. CONCLUSIONS

Narcissism psychotherapy is a difficult and challenging process. Therefore, it is advisable that the initial assessment of a person with a diagnosis of narcissistic personality disorder should be done following a clinical interview and the use of standardized measurement instruments adapted to the Romanian population.

A comprehensive assessment will include: the reasons why the client sought psychotherapy, the existence of comorbidities, an assessment of the severity of the pathology, psychiatric history, obtaining data on present mental status, and screening for risk factors such as suicide, self-harm or harm to others. Understanding how maladaptive narcissistic personality cores affects the person's life, family and socio-relational world is the first step in narcissism psychotherapy.

If comorbid disorders require specific medication to reduce symptoms and possible life-threatening risks, psychotherapeutic intervention will be accompanied by psychopharmacologic intervention.

In psychotherapy, a structured form of psychotherapy will be used, supported by specialized literature, using techniques and methods likely to target the main features of the disorder.

It is recommended that the psychotherapist has been trained and certified in the psychotherapeutic model they wish to use.

It is also recommended to measure the intermediate and final outcomes of the psychotherapeutic process in order to determine its effectiveness, to quantify the evolution of the client's symptomatology and to make informed clinical prognoses about the evolution of the disorder, including possible relapses.

Last but not least, it is necessary that psychotherapists working with people with narcissistic pathology benefit from a professional support group, either through regular intervention or supervision with a specialist in the field.

The literature review specific to the psychotherapy of various personality disorders, as well as the clinical study presented above, have provided us with the first milestones in the design of a psychotherapeutic guide for working with narcissistic individuals, with techniques and interventions adapted to both grandiose and vulnerable narcissism.

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