

# NARCISSISTIC PERSONALITY DISORDER

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DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, THIRD EDITION  
(DSM-III), REVISED

Individuals with this personality disorder have an excessive sense of how important they are. They demand and expect to be admired and praised by others and are limited in their capacity to appreciate others' perspectives.

## Diagnostic criteria

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2. is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4. requires excessive admiration
5. has a sense of entitlement (e.g., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations)
6. is interpersonally exploitative (e.g., takes advantage of others to achieve his or her own ends)
7. lacks empathy is unwilling to recognize or identify with the feeling and needs of others
8. is often envious of others or believes that others are envious of him or her 9.) shows arrogant, haughty behaviors or attitudes

## Medical treatment

### Hospitalization

The hospitalization of patients with severe Narcissistic Personality occurs frequently. For some, such as those who are quite impulsive or self-destructive, or who have poor reality testing, which are overlaid upon the personality disorder. Hospitalizations should be brief, and the treatment specific to the particular symptom involved.

Another group of patients for whom hospitalization is indicated, provided long-term residential treatment is available, are those who have poor motivation for outpatient treatment, fragile object relationships, chronic destructive acting out, and chaotic lifestyles. An inpatient program can offer an intensive milieu, which includes individual psychotherapy, family involvement, and a specialized residential environment. The structure is physically and emotionally secure enough to sustain the patient with severe ego weakness throughout the course of expressive, conflict-solving psychotherapy.

Small staff-patient groups within the wards, as well as large community meetings, at which feelings are shared and patients' comments taken seriously by staff, and constructive work assignments, recreational activities, and opportunities to sublimate painfully conflictual impulses make the hospital a "holding" environment rather than merely a containing one. The ultimate goals are of affecting a better-integrated internal world, more cohesive and modulated self-





object representation, and a self-concept less vulnerable to narcissistic injury.

## Psychosocial Treatment

### Basic principles

Narcissistic patients try to sustain an image of perfection and personal invincibility for themselves and attempt to project that impression to others as well. Physical illness may shatter this illusion, and a patient may lose the feeling of safety inherent in a cohesive sense of self. This loss precipitates a panicky sensation that "my world is falling to pieces," and the patient feels a sense of personal fragmentation.

The histrionic patient's idealization of the physician stands in contrast to the narcissistic patient's frequent contemptuous disregard for the physician, who is denigrated in a defensive effort to maintain a sense of superiority and mastery over illness. Only the most senior physician in a prestigious institution is deemed worthy of respect as the frightened patient seeks an external reflection of his or her own fragile grandeur in the doctor. More junior members of the health care team may be the targets of derision as the patient seeks to establish hierarchical dominance to counter the shame and fear triggered by illness.

Health care professionals must convey a feeling of respect and acknowledge the patient's sense of self-importance so that the patient can re-establish a coherent sense of self, but they must at the same time avoid reinforcing either pathologic grandiosity (which may contribute to denial of illness) or weakness (which frightens the patient). An

initial approach of support followed by step-by-step confrontation of the patient's vulnerabilities may enable the patient to deal with the implications of illness with feelings of greater subjective strength. The increased self-confidence may reduce the patient's need to attack the health care team in a misguided effort at psychologic self-preservation and eases the pressure to provide perfect care, since the patient's antagonistic feeling of entitlement (defined by the DSM-III as an "expectation of special favors without assuming reciprocal responsibilities") is reduced.

Many of the treatment principles and approaches discussed for this disorder apply as well to borderline personality disorder.

The individual with narcissistic and related personality disorders is likely to present with various symptoms and disorders at various times in his or her life. Caution should be observed not to over-diagnose psychotic decompensation as Schizophrenia unless all DSM-III criteria are apparent. The same caveat applies to the pharmacologic treatment of depressive symptoms in the absence of clinical signs of Major Affective Disorder.

When treating presenting symptoms and disorders in patients with narcissistic personality disorder and other similar conditions, attention should be paid to the consequences of removing symptoms in a patient whose underlying character is primitive and or fragile.

Some clinicians suggest that the grandiosity and tendency to idealize and devalue should be interpreted as defensive maneuvers when





aspects of early conflictual relationships are played out in adult life. Other clinicians posit that the emergence of the patient's grandiosity and tendency to idealize the therapist should initially be viewed supportively. To help the individual develop stronger self-esteem regulation, the therapist then gradually points out the realistic limitations of patient and therapist alike while also offering an empathic ambience to cushion patients in their efforts to accept and integrate these experiences. Unfortunately, much research will be required to validate the description and course of narcissistic personality disorder before further research can answer which techniques bring about a better response to treatment.

### Individual psychotherapy

Most psychiatrists will, as a practical matter, treat most of their severely narcissistic patients for symptoms related to crises and relatively external diagnoses, rather than in an effort to address the personality disorder itself. The therapist must be aware of the importance of narcissism to the contiguity of the patient's psyche, refrain from confronting the need for self-aggrandizement, and help the patient use his or her narcissistic characteristics to reconstitute an intact self-image. Positive transference and therapeutic alliance should not be relied upon since the patient may not be able to acknowledge the real humanness of the therapist but may have to see him/her as either superhuman or devalued.

Those patients who do not terminate treatment after symptom relief has been obtained may wish help for some of the problems related to their personality

disorder, such as interpersonal difficulties or depression. The therapist must have a good understanding of the narcissistic personality style, both for interpretation to the patient and for use in combating countertransference. Goals for ordinary psychotherapy should not be too great since the source of these patients' difficulties lies deep in pathological development.

### Group therapy

The goals are to help the patient develop a healthy individuality (rather than a resilient narcissism) so that he or she can acknowledge others as separate persons, and to decrease the need for self-defeating coping mechanisms. The first step toward developing a working alliance is empathy with the surprise and hurt that the patient experiences because of confrontations within the group. The external structuring group therapy provides can control destructive behavior despite ego weakness. In groups, the therapist is less authoritative (and less threatening to the patient's grandiosity); intensity of emotional experience is lessened; regression is more controlled, creating a better setting for confrontation and clarification.

Outpatient analytic-expressive group therapy requires a concomitant individual relationship for most patients, which should be somewhat supportive. The need for this additional support, the likelihood of the patient's leaving the group at the first sign of psychic insult, and proneness to disorganized thinking are all found more often in the Borderline patient. The patient with a narcissistic personality disorder does not appear so vulnerable to separation anxieties





as the Borderline patient but is instead involved in issues centered around maintaining a sense of self-worth.

"Knowledge is power."

