Personality Disorders- Narcissistic Personality Disorder (NPD)

DSM-IV-TR Diagnostic Code: 301.81 Narcissistic Personality Disorder

Diagnostic Guidelines:

1. Establish Diagnostic accuracy as defined in DSM-IV-TR.

2. Identify differential diagnoses and co-morbid problems: Rule out mania, substance related disorders, and other Cluster B personality disorders. Use psychological testing to assist with rule outs when treatment based on standard clinical evaluation and treatment approaches is ineffective or fails to improve the client's mental status and related life experiences.

3. Establish accurate diagnosis through continued assessment of diagnosis over time and rule out of other diagnoses as necessary.

4. Obtain external corroboration of diagnosis when possible through review of past treatment history, legal history, etc.

5. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains.

Treatment Guidelines

1. Individuals with personality disorders usually come for therapy with presenting issues other than personality problems -- most often substance abuse, depression and anxiety. They often see the difficulties that they have with others as external and independent of their behavior or input (Beck, 1990, pp. 5-6). Individuals with NPD do not tolerate discomfort well and most commonly enter therapy for depression. NPD depression is often precipitated by a crisis that punctures the narcissistic grandiosity and reflects the discrepancy between NPD expectations or fantasies and reality (Beck, 1990, p. 239).

2. Individuals with NPD may have trouble entering treatment because they experience needing help as demeaning and unacceptable. However, if they are in a severe enough crisis, they may well seek therapy to retrieve their feelings of confidence, a sense of easy superiority, and the capacity to sustain themselves with self-glorifying fantasies. Their view of themselves, their past, their current situation, and what they need from treatment will all be distorted by their need for self-aggrandizement. They will resist reality-based feedback and may flee the treatment setting if they are not sufficiently affirmed and comforted with an inflated view of themselves. It may be necessary to cooperate in the narcissistic need for sustenance to develop a therapeutic relationship. However, the return to

comfort for individuals with NPD may be all that they are seeking and they will leave treatment anyway. It becomes an assessment and treatment challenge to connect well enough with these individuals to allow for realistic feedback and the development of more adaptive behaviors.

3. Clinicians must convey a feeling of respect and acknowledge the client's sense of self-importance so that the client can 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. An initial approach of support followed by step-by-step confrontation of the client's vulnerabilities may enable the client to deal with the implications of this disorder.

4. The narcissistic client is frequently contemptuous of the clinician, degrading them in a defensive effort to maintain a sense of superiority and mastery. Only the most senior clinician in a prestigious institution is deemed worthy of respect, which the frightened client uses as a defense. More junior members of the health care team may be the targets of derogatory statements as the client seeks to establish dominance in order to counter the shame and fear triggered by the disorder.

5. When treating presenting symptoms and Axis I disorders in clients with NPD, attention should be paid to the consequences of removing symptoms in a client whose underlying character is primitive and/or fragile. Removing defenses may precipitate crisis behaviors.

6. The clinician must have a clear understanding of the principles of the narcissistic personality style, both for interpretation to the client and for use in combating countertransference. Goals for therapy should be small and attainable.

7. The client with NPD is focused on maintaining a sense of self-worth. This can be addressed in a group setting by developing a working alliance empathizing with the surprise and hurt that the client experiences as a result of confrontations within the group. The external structuring group therapy provides can control destructive behavior in spite of a weak ego. In groups, the clinician may seem less authoritative and less threatening to the client's grandiosity, the intensity of emotional experience is lessened and regression is more controlled, creating a better setting for confrontation and clarification.

8. Medications are not indicated, except for the treatment of specific, concurrent Axis I diagnoses.

References:

Beck, Aaron T. and Freeman, Arthur (1990). *Cognitive Therapy of Personality Disorders*. New York: The Guilford Press.

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Gelder, Michael, Gath, Dennis, Mayou, Richard, Cowen, Philip (eds.), *Oxford Textbook of Psychiatry*, third edition, Oxford University Press, Oxford, 1996, (reprinted 2000).

Gabbard, Glen O (Ed); Beck, Judith S (Ed); Holmes, Jeremy (Ed). *Oxford Textbook of Psychotherapy*. (pp. 279-289). ix, 534 pp., 2005.

Robert C. Schwartz, Ph.D., DAPA and Shannon D. Smith, Ph.D., DAPA, "Psychotherapeutic Assessment and Treatment of Narcissistic Personality Disorder" (American Psychotherapy Association, Article #3004 Annals July/August 2002).