

# Narcissism is Treatable. The Priority for Dominance in Narcissistic Personality Disorder and Traps to Avoid in Psychotherapeutic Treatment

Mini Review

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## Abstract

The characteristics and obstacles that literature has identified in the narcissistic personality disorder (NPD) can be traced back to a motivation, often underlying but omnipresent: the priority for dominance, which shapes thoughts, actions, desires and communication style in the patient with narcissistic personality disorder (pwNPD). This priority, being in pwNPDs a veritable compulsion to dominance, blinds the patients, often preventing them from relying on the others, recognising their problems and embarking on a path of personal change. Several theories outline therapeutic approaches to NPD, but existing treatments are limited in terms of effectiveness, and are frequently associated with no progress or an unfortunate outcome. However, some authors, on the basis of their own clinical experience and a careful analysis of the scientific literature on the subject, have identified some guidelines, and highlighted some common traps. They aim at promoting the development of more effective psychotherapeutic approaches inspired by more pragmatic principles, rather than being rigidly anchored to their own theoretical frameworks of reference.

**Keywords:** Narcissism; Narcissistic personality disorder; Priority for dominance; Dominance compulsion; Psychotherapy; Treatment guidelines

**Abbreviations:** NPD: Narcissistic Personality Disorder; pwNPD: Patient With Narcissistic Personality Disorder; pwNPDs: Patients With Narcissistic Personality Disorder

## Mini Review

The main characteristics that can be noticed in a patient suffering from narcissistic personality disorder are well known: self-exaltation, grandiose self-perception, constant need for admiration, relational exploitation, presence of a merely cognitive empathy, fantasies of unlimited success [1]. According to recent estimates, the prevalence of pwNPDs varies from 0% to 6% in the general population, from 1.3% to 20% in the clinical population, and from 8.5% to 20% according to a private practice; a pwNPD is more prone to show disorders connected to mood, anxiety and substance use, is more prone to commit suicide,

and is more prone to have significant problems of professional and relational nature [2,3].

### Why is NPD So Hard to Treat?

While it is important to separate the person from the disorder and its multiple manifestations, and to recognise that the NPD can be more or less treatable (there are different degrees of treatment readiness and more or less favourable prognoses), the psychological literature highlights certain characteristics and obstacles - briefly listed below - that are typical in the psychotherapeutic treatment of pwNPDs [4-6]. All these obstacles and characteristics can be traced back to an underlying and omnipresent motivation in pwNPDs: the implicit or explicit priority for dominance, which shapes thoughts, actions, desires and communicative style of pwNPDs, and which blinds the patients, often



preventing them from relying on the others, recognising their problems and embarking on a path of personal change [7]. In order to understand the causal basis of behaviour, it is necessary to understand the constantly changing priorities that at times lead a person to engage in a certain behaviour and then - a few seconds, minutes or hours later - lead the same person to carry out completely different actions [8]. The priority for dominance can be regarded as one of the basic motivations of human acting, but in the case of NPD it is radicalised to such an extent that it becomes a veritable compulsion to dominance [7]. Keeping in mind this priority (to be respected and transformed at the same time) can help the clinician to better decrypt and manage the typical characteristics and obstacles of the NPD:

- PwNPDs are not aware of their narcissism; they are more prone to recognise that they need help in other areas (sleep, mood, somatisation, anxiety or panic disorder). Life ultimatums are one of the main reasons why a pwNPD resorts to psychotherapy: being at the crossroads, facing an internal change or a major loss, usually related to professional failure, legal issues, separation/divorce [9]. Another possible motivation that leads pwNPDs to seek psychotherapeutic support is their feeling of fragmentation, loss of direction and meaning in their lives.

- The manifest behaviour of pwNPDs is not aligned with their inner experience: the actions performed (e.g., the flaunted self-confidence) are strategies which have been used (successfully) throughout their lives to survive experiences of shame / worthlessness / fear / incoherence / fragmentation, triggered by early traumatic relational experiences. These experiences, not having been fully processed (let alone acknowledged), get reactivated every time pwNPDs enter into a meaningful relationship.

- Their grandiosity, explicit or implicit, may be accompanied by real and great skills. However, their self-esteem tends to be based only on these performances, rather than other personal qualities. This implies a great struggle for pwNPDs to recognise their own limitations / failures / weaknesses; if they did, they would perceive a threatening and catastrophic demolition of their own value.

- PwNPDs face a complex relational challenge: they did not experience a primitive, healthy and empathic relational dependence on attachment figures. Therefore, they tend to adopt an adversarial attitude: on the one hand, they fear empathy and affective closeness but, on the other hand, they need to be seen / recognised in their own value, identity, and emotional suffering.

- The need related to control, context and to their own affective states, prevents pwNPDs from relying on the others. PwNPDs cultivate the belief that, within relationships, they may be exposed to misuse of power and humiliating rejection. Hypervigilance towards signs of a potential relationship loss - and difficulties in experiencing affective empathy - lead them to humiliating interpretations of others' behaviour, thus feeling an urge to defend themselves in order to restore their own perception of integrity, independence and relational control.

### **What are the Vulnerabilities of pwNPDs, which can be Triggered in a Psychotherapeutic Relationship?**

PwNPDs show typical - and particularly significant - vulnerabilities, which hinder the relationship with the psychotherapist [10]:

- The need, on the pwNPDs' side, to exert their autonomy, and the need to have a high degree of control over the therapeutic relationship.

- The awareness related to the different levels of power: in the therapeutic setting, the psychotherapist 'has the power', and pwNPDs expect that it will be misused.

- The difficulty in relying on the psychotherapist and managing emotional dependence, without it leading them to experience feelings of shame and humiliation.

- The awareness related to verbal and non-verbal signals of humiliation, real or alleged.

- The use of narcissistic control strategies, such as manipulation, lying and dissimulation.

- The gap in affective empathy.

### **What do we know about psychotherapeutic treatment of pwNPDs?**

Several theories outline therapeutic approaches to NPD; however, none of them have been tested in randomised controlled trials, and when pwNPDs were included in the survey sample, their figure was so small that statistical results could not be generalised [11-16]. Existing treatments are limited in terms of effectiveness and are frequently associated with no progress or an unfortunate treatment outcome, with a high rate of premature and sudden discontinuation [17,18] and increased persistence of symptoms after psychotherapy [19]. In general, there is a rather compliant attitude towards the possibility of treating pwNPDs.

Some authors [10], on the basis of their own clinical experience and on the basis of a careful analysis of the scientific literature on the subject, have identified some effective guiding principles, highlighting some common traps in order to promote the development of more effective psychotherapeutic approaches. Their goal is to develop a pragmatic, goal-oriented (a crucial factor for pwNPDs) psychotherapeutic approach to overcome the theoretical reference models. At the same time, this approach should also offer a remedial emotional experience or functional alternatives to the patients' typical self-defence solutions.

### **Which Elements help the Psychotherapeutic Process?**

Three positive prognostic factors are essential [10]:

- A strong therapeutic alliance;

- Autonomous motivation for therapy;

- The identification of therapeutic goals that are both ameliorative of the narcissistic pathology, and desirable for the patient.

Since the therapeutic alliance with pwNPDs is susceptible to ruptures, allowing patients to have an autonomous motivation for therapy helps them to develop a sense of agency, and to stay focused on their own change rather than on maintaining the status quo. Sometimes, the identification of therapeutic goals may require a long effort, as patients tend to withdraw from a meaningful discussion about them, through the dynamic of a grandiose self-perception put in place to avoid experiencing uncertainty, inadequacy and failure. Patience is needed to allow patients to develop trust in the treatment; the psychotherapist can facilitate this trust by adopting a curious and non-judgmental stance towards the patients, and by inviting them to be curious about these same obstacles.

### **What should the Psychotherapist Know**

PwNPDs must be understood in the complexity of their way of adapting to reality; therefore, it is necessary to get to know them in small steps. Some considerations:

- Building and maintaining the therapeutic alliance with pwNPDs requires patience: it constitutes a central element for the adherence to treatment and it is also an objective of psychotherapy itself. For this reason, the specific vulnerabilities of the pwNPDs must be considered in order to preserve the therapeutic relationship.

- The psychotherapist must overcome the traditional patterns



of intervention and consider themselves as an element of constant and mutual building of the therapeutic relationship.

- The psychotherapist should be able to tolerate the feeling of confusion and the perception of being inadequate and not sufficiently prepared - a feeling typically triggered by the relationship with pwNPDs. Tolerating these experiences is part and parcel of the treatment.
- It is important that patients genuinely perceive that they have a functional and effective control over the treatment: psychotherapeutic goals and approaches must be perceived as controllable.
- The recommended starting point involves great patience and sensitivity towards the pwNPDs' susceptibility to feelings of humiliation and shame, or to feeling blamed, trapped and defeated.

### **The Most Common Traps for a Psychotherapist Treating NPD [cf. 10, 20]**

**Psychotherapist's trap NR. 1:** Guiding the patients only towards the goals indicated by the psychotherapeutic reference model.

**Alternative solution proposal:** Helping pwNPDs to identify goals that are measurable and perceived as their own.

Treatment goals must be desirable for the patients, as well as useful for the change of the narcissistic psychopathology. The prognosis depends on how well the patients can visualize the benefits of change: the patients will only be able to tolerate giving up defensive control strategies and ingrained-narcissistic interaction patterns (withdrawal, manipulation, compliant conformity) if they see a personal benefit. As part of the identification of therapeutic goals, it is important to provide a psycho-education on NPD, especially on how its characteristics contribute to other comorbidities (such as anxiety disorders and addictions), thus undermining the achievement of important personal goals.

These two guidelines can be used in order to combine patient wishes and improvement of narcissistic psychopathology:

- Gradually, and collaboratively, identify and redefine the patient's treatment and life goals. They should be realistic, clear, measurable, meaningfully related to the patients' values and to the change they expect for themselves [21-23], but also to an authentic self-concept [24,25]. These goals should not be confused with the pursuit of grandiosity for its own sake.
- Showing genuine curiosity towards the obstacles hindering a balanced identification of therapeutic goals: this is how patients are implicitly invited to get curious about these obstacles first. If the motivation towards the realisation of therapeutic goals is perceived as personal, the patients will be able to independently challenge their grandiose self-perception.

**Psychotherapist's trap NR. 2:** Directly challenging or over-indulging the grandiosity and self-hatred experienced by patients.

**Alternative solution proposal:** Facilitating the shift from grandiosity and self-hatred to the recognition of personal skills and the nobility of personal goals.

Although the patients may have a history of neglect, deprivation, lack of protection, and trauma [26-28] leading them to adopt the defensive mode of grandiosity, the psychotherapist should still consider the active role of the patients in perpetuating their own suffering. This awareness, gradually communicated to the patient, will allow the shift towards a more genuine self-expression, a core point in pwNPDs' change [24,29,30]. This process occurs one step at a time, when pwNPDs begin to rely more both on themselves and on the psychotherapist, whose presence is felt as genuinely interested in the patient's well-being. This trust allows pwNPDs to develop their skills and desire to recognise and share thoughts, feelings and observations.

Grandiosity and self-hatred are present in pwNPDs as they fulfil a dual purpose: on the one hand they help the patients to detach from their real experiences (e.g. failure to meet their own standards), on the other hand they allow them to gather the energy needed to move towards grandiose goals (thus avoiding potential failure). This attitude, however, results in limited experience in authentic self-expression. The psychotherapist should refrain from directly challenging the pwNPDs' excessive grandiosity and need for admiration: if the patients perceive that their own commitment and skills are not recognised, they will angrily act to demonstrate the opposite. On the other hand, if the psychotherapist praises the patients excessively, this will also make them feel misunderstood regarding the complexity of their personal experiences; pwNPDs, in fact, tend to respond to praise with disengagement, distrust and rejection of treatment.

It is useful then to:

- Gradually explore the function and effect, both positive and negative, of grandiose beliefs/ strategies and self-hatred [23,31,32]: patients, as they begin to recognise the ineffectiveness of these beliefs/ strategies, gradually give up on them.
- Acknowledge real talents and actual practical skills of pwNPDs: this attitude helps the patients to make a distinction between the need for admiration and the recognition of real skills and talents.
- Encourage awareness about the triggers that cause fluctuations in self-esteem, and identify effective coping strategies.
- Consider those life events that may have fomented grandiose beliefs/strategies and self-hatred: patients may detach from their real experiences if the treatment only aims at focusing on the therapeutic relationship.

**Psychotherapist's trap NR. 3:** Neglecting the patient's limits and difficulties in terms of skills.

**Alternative solution proposal:** Promoting a sense of agency in patients, linked to meaningful goals.

PwNPDs catastrophically experience the perception and/or awareness of having lacks in certain life skills or areas (cognitive, emotional, and relational). This painful perception leads to a decrease in excitement towards meaningful long-term goals, general motivation for treatment, and extreme self-criticism and shame/self-hatred. However, the psychotherapist may overlook the need to mobilise the patients' agency (the perception of consciously leading one's own life). Self-agency is an important change agent in NPD psychotherapy [33-35]: only when patients experience a sense of agency, they feel safe enough to expand their thinking capacity and to share the contents of those thoughts.

What to do then? Collaboratively define both the therapeutic goals and the goals related to activities which are outside the treatment (e.g. training skills not directly related to the treatment), in which the patients perceive themselves as 'pilots'. The perception of a co-constructed therapeutic relationship allows the patients not to feel too vulnerable and dependent on the psychotherapist [34].

**Psychotherapist's Trap NR. 4:** Excess of empathy.

**Alternative solution proposal:** Offering the 'right' dose of empathy.

PwNPDs are sensitive to self-determination, relational control and 'territoriality'. They have often grown up in environments, and intimate relationships, with sporadic expressions of real empathy. The psychotherapist's overuse of empathic interventions could make the patients feel invaded, exposed to control attempts and possible humiliation [36-37], resulting in feelings of loss of control, disorientation and anxiety [38]. What are the alternatives?



Empathy should be moderated, without being eliminated; open questions can be used to explore the experiences generated in patients after such empathic interventions.

**Psychotherapist's trap NR. 5:** Engaging in a power struggle - real or alleged - and misuse of power.

**Alternative solution proposal:** Encouraging a sense of security and agency in pwNPDs.

PwNPDs strive very hard to be in control and they need to feel in charge of the therapeutic treatment. When a power struggle - real or alleged - arises, many pwNPDs will:

- cancel appointments with the psychotherapist, or even the whole treatment;
- refuse to talk or, if they do, act superficially;
- get angry, or threat, even to the point of filing lawsuits.

This happens in order to keep control and feel to be protected. Authoritarian interventions are not advisable, as they may lead to false compliance with treatment, or to a dead end.

Better options for psychotherapists:

- sensitivity development towards the actual power differentials between the therapists' and the patients' positions, tracking the resulting effect both on themselves and on pwNPDs [39]
- exploring, together with the patient, the meaning of power differentials and obstacles in the process of collaboration/ dependence on the psychotherapist
- validating the patients' intolerance towards the different perspectives between them and the psychotherapist: being curious towards the reactions to such differences, will enable the patients to tolerate them;
- promoting a full acceptance of the internal contradictions perceived by the patients, thus experiencing a sense of acceptance and belonging over them.

**Psychotherapist's trap NR. 6:** Ignoring the countertransference.

**Alternative solution proposal:** Tracking personal and automatic reactions, and keeping a supervisory consultation with a fellow psychotherapist.

Although countertransference is an important element of psychotherapy, it also represents the most common standoff and failure in treating pwNPDs. Once recognised, countertransference provides information about the patient's inner self and relational style, characterised by specific expectations and struggles [40]. However, the impact is so strong that it can undermine the stability of the psychotherapist and the ongoing treatment.

Psychotherapists report feeling annoyed, used, abused, resentful, criticised, or rejected. They may feel terrified, bored or tense, and sometimes they wish to become cruel and mean to the patients [41,42]. Despite the psychotherapist's best efforts, overt expressions of countertransference are not entirely avoidable. There are, however, some expedients to turn these limitations into a therapeutic advantage, including openly expressing the countertransference reactions to the patients. These include: distancing from the patients, wishing to discontinue treatment, irritation towards the patients, competing with the patients, trying to make the patients 'fail' or treating them as helpless victims.

Specific remedies:

- Establishing an ongoing or occasional consultation with a colleague for supervision: processing such reactions limits the risk of expressing them;

- Helping the patients to gradually integrate the countertransference experiences lived by the psychotherapist into their self-concept and self-narrative;

- Discussing the topic with the patients, inviting them to be curious about this process and encouraging them to consider it as a co-created story between them and the psychotherapist.

**Psychotherapist's trap NR. 7:** Insistently urge the patients to process their emotions, even when they feel fragile and threatened in their self-esteem.

**Alternative solution proposal:** Analyse the patient's readiness before proceeding with further exploration and elaboration of the emotional experience.

Patients who perceive a threat - real or alleged - to their self-esteem and identity triggered by the therapeutic approach, may show various attempts at emotional self-regulation:

- Interpersonal withdrawal from the therapeutic approach, frequently associated with shame and contempt;
- Interpersonal attack on the psychotherapist, associated with competition, criticism and manipulation;
- Compliant conformity to the requests made by the psychotherapist;
- Availability and agreement with the psychotherapist (genuine collaboration).

Several studies provide evidence of the presence of neuropsychological gaps in pwNPDs in emotion processing, which affect their ability to access, tolerate, identify and verbalise their own and others' emotions. This gap is accompanied by difficulties in integrating personal feelings and intentions into interpersonal interactions [43,44]. This factor may indicate that emotions, personal or not, may be perceived as rewarding, challenging or threatening not only with respect to actual relational events, but also with respect to the personal self-perception of struggling to process them, thus threatening the personal sense of competence and control and, consequently, the personal self-esteem [45]. What to do:

- Genuinely validate the patients' challenges and emotional experiences in a non-judgemental way: it may be useful to value some narcissistic defences, in order to deepen and understand their functions.

- The patients' relational withdrawal or refusal may indicate the resurfacing of an early relational trauma, or a struggle in emotional processing: respecting the patients' willingness to further exploration may avoid divisions in the therapeutic alliance.

- Guide the patients, through a calm, emotional support, to experience the consequences of their behaviour: pwNPDs will thus have the opportunity to discover the reactions of other people, as well as their own personal limits.

- Encourage agency: pursuing meaningful goals, rather than an unrealistic, grandiose self-perception, may enable the patients to overcome the sense of inferiority hidden behind grandiosity.

## Conclusion

For psychotherapists, treating pwNPDs represents a constant and personal challenge, both on a human level, having to establish a relationship with the individual, and on a theoretical level, due to their personal orientation. The latter is inevitably inadequate in the face of NPD. The relational framework with pwNPDs is complicated by the omnipresent psychological priority - either implicit or explicit - to dominate the scene, even in the therapeutic relationship. In this regard, the psychotherapist might become a mere helper to be used and



exploited, or a challenger to harshly engage with. As a consequence, it will be impossible to establish a relationship that can be instead truly genuine, deep, and caring, beyond those feelings of shame, invasion, and humiliation typical in pwNPDs.

Over the years, research has shown that the treatment of NPD requires a goal-oriented, pragmatic mindset and a joint research between psychotherapists and patients to find applicable solutions, both appealing for the patients and transformative for the psychopathology. By respecting, using and leveraging the priority for dominance in pwNPDs, the psychotherapist guides the patients to evolve and transform it, thus enabling them to open up to a deep relationship with the others, so that excelling does not equate with domination, but with being able to love and serve the others. A horizon that can therefore open up to ethical references, to values that know how to harness the impulse towards domination and self-preservation. Ethics that begin with wanting to ask this question, and knowing the answer: “What is more important than me?” [46]. Narcissism can be cured.

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