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The Dual Diagnosis Pages: "From Our Desk"
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Dual Diagnosis and the Narcissistic Personality Disorder

Table of Contents

Cluster B:
The Narcissistic Personality Disorder (NPD)
Essential Feature

The essential feature of the narcissistic personality disorder is a pervasive pattern of grandiosity, need for admiration, and lack of empathy
(DSM-IVô, 1994, p. 658). Gunderson, et.al, (Livesly, ed., 1995, p. 208)
notes that the grandiosity may not be overt or may involve arrogant and
haughty behavior.

Kantor (1992, pp. 203-204) describes the clinical characteristics of NPD
as:

inordinate self-pride;

self-concern;

an exaggeration of the importance of one's experiences and feelings;

ideas of perfection;

a reluctance to accept blame or criticism;

absence of altruism although gestures may be made for the sake of appearance;

empathy deficit; and,

grandiosity.
Frances, et.al. (1995, p. 374) add:

entitlement;

shallowness;

preoccupation with fame, wealth, and achievement;

craving admiration, attention and praise;

placing excessive emphasis on displaying beauty and power.

Beck (1990, p. 49) describes the key elements of NPD as presumed superiority and self-aggrandizing behavior. These individuals also give evidence of intense motivation to seek perfection and a feeling state of emptiness, rage and envy (Masterson, 1981, p. 7). They are vulnerable to the most negligible slights and are prone to withdraw and become inaccessible when feeling offended (Benjamin, 1993, p. 141).

Individuals with NPD may show little real ability outside of their fantasies. They can become self-destructive because their grandiosity and self-preoccupation impair their judgment and perspective. They can experience such inappropriate rage in response to someone diminishing their sense of superiority that they attack and attempt to destroy the source of criticism (Oldham, 1990, pp. 93-95). These individuals have a particularly difficult time with the limitations inherent in ageing; NPD has been associated with deterioration in midlife with the realization of mortality and loss of physical vitality (Wink, Costello, ed., p. 149).

On the other hand, individuals with NPD may be talented and successful

enough to be admired and emulated by others (McWilliams, 1994, p. 171).
They can be nearly symptom-free and well functioning. Even so, they may
still be chronically unsatisfied due to habitually unrealistic
self-expectations (Sperry & Carlson, 1993, p. 316).

NPD may be comorbid with histrionic, borderline, antisocial, and paranoid
personality disorders. NPD traits are common in adolescents and may not
necessarily lead to NPD in adulthood. Individuals who are diagnosed with
NPD are 50-75% male (DSM-IVô, 1994, p. 660).

Self-Image

Individuals with NPD have a grandiose sense of self-importance. They
routinely overestimate their abilities, inflate their accomplishments, and
appear boastful, arrogant, and pretentious (DSM-IV, 1994, p. 658). This
belief in personal superiority is the "bedrock" of their self-image.
Individuals with NPD believe that their presumption of superiority is
sufficient proof of its existence. They are able to feel secure and
content if they think highly of themselves. Negative aspects of self are
met with denial or rationalization (Richards, 1993, p. 251). However,
maintenance of the belief that they are superior, often without
commensurate achievements, can create a painful disparity between their
genuine and their illusory competence. The strain of maintaining a false
self-image may lead to feelings of fraudulence, emptiness, and
disconsolate feelings (Millon & Davis, 1996, pp. 393, 420-421). McWilliams
(1994, pp. 177-178) believes that individuals with NPD have some sense of
their psychological fragility. They can experience either a grandiose
self-state or a depleted, shamed self-state. With external affirmation,
they can feel self-righteous, prideful, contemptuous of others,
self-sufficient, and vain. With the loss of external validation, they can
feel a vague sense of falseness, envy, ugliness, and inferiority.

Kantor (1992, p. 207) believes that individuals with NPD can sustain good
judgement if they demand performance of themselves that vindicates their

self-esteem. Judgement becomes impaired when the self-love has little realistic basis. Even as these individuals inflate their efforts and overvalue their abilities, they seem surprised when they do not receive the praise they expect (DSM-IVô, 1994, p. 658). They appear to have little awareness that their behavior may be seen as objectionable or irrational (Millon & Davis, 1996, pp. 405-406).

View of Others

Individuals with NPD assume that other people will submerge their desires in favor of the comfort and welfare of those with NPD. They believe that just because they want something -- that is reason enough for them to have it. They assume that others are as consumed by concern for those with NPD as the individuals themselves are; they believe they deserve special consideration from others (DSM IVô, 1994, p. 659) (Millon & Davis, 1996, p. 394). Narcissistic individuals use others to fulfill their own psychological needs and to maintain the stability of the self; others are valued by how well they provide comfort and emotional stability (Wink, Costello, ed., 1996, p. 149).

Kantor (1992, p. 206) notes that individuals with NPD have trouble cooperating with other people as their attention is on themselves. They view others as vassals or constituents; they seek admiration to document their own grandiosity and to preserve their superior status (Beck, 1990, p. 49). They have difficulty recognizing the experience and feelings of others. They lack empathy and form few genuine emotional commitments. They must, at all times, be admired. If they are able to recognize the needs of others, they tend to view these factors as signs of weakness and vulnerability (DSM-IVô, 1994, p. 659) (Oldham, 1990, p. 96). When able to perceive this vulnerability, individuals with NPD behave in a dominant and coercive manner (Birtchnell, Costello, ed., 1996, p. 186).

Individuals with NPD are often envious of others and believe others to

be
envious of them. They begrudge others their possessions or successes. They
believe that they are so important that others should defer to them; their
sense of entitlement is apparent in their lack of sensitivity toward and
arrogant exploitation of others (DSM-IVô, 1994, pp. 658-659).

NPD self-esteem is fragile and maintained by external affirmation (McWilliams, 1994, p. 168). These individuals are preoccupied by how well
they are perceived by others. They enhance their self-image by associating
with people who are also superior, special or unique, and of high status;
they want to be connected to people of equally idealized value (DSM-IVô,
1994, pp. 658-659).

Relationships

NPD relationships are impaired because of entitlement, need for admiration, and disregard for the feelings of others (DSM-IVô, 1994, p.
659). Individuals with NPD are interpersonally exploitative; they expect
special favors without reciprocal responsibilities (Millon & Davis, 1996,
pp. 405-406). Their capacity to feel love for others is marginal (McWilliams, 1994, p. 175) and they possess only the kind of empathy that
allows them to manipulate and elicit admiration from others (Wink, Costellos, ed., 1996, p. 159). They can be socially facile, pleasant, and
endearing; however, they are unable to respond with true empathy and can
be disdainful and irresponsible (Sperry, 1995, p. 114). Their relationships must have potential for advancing their purposes or enhancing their self-esteem (DSM-IVô, 1994, p. 659). Without any apparent
pay-off, a relationship has no purpose and is unlikely to be sustained.

A grave concern regarding individuals with severe NPD is their cold seductiveness and promiscuity, their incapacity to stay in love, and their
inability to either genuinely comprehend or accept the incest taboo (Akhtar, 1992, p. 69). If they do not see their children as separate individuals but as sources of need gratification, sexual behavior is

possible.

Yet, in spite of the apparent self-sufficiency of individuals with NPD, they have intense interpersonal needs (Golomb, 1992, p. 21). Their need for external affirmation of their specialness means they must be in relationships that will allow them to feel unique and admired. This overburdens their relationships with their demands for self-esteem enhancing interaction (McWilliams, 1994, p. 174) and they are likely to contribute little or nothing in return for the gratifications they seek. It is central to NPD that good fortune will come without reciprocity (Millon & Davis, 1996, pp. 405-406).

Individuals with NPD are likely to attempt to get their needs met in relationships without acknowledging the independent existence of those from which they "expect to feed." If they are forced to recognize the presence of a benefactor. they demean the gift or the person who has given it. Mates for individuals with NPD often have a NPD parent who has already indoctrinated them to regard exploitation and disregard as love (Golomb, 1992, pp. 21-22). Individuals with NPD are prone to compete with their mates; they want to be with someone special but they do not want to lose the spotlight (Beck, 1990, p. 244).

Within relationships, individuals with NPD expect admiring deference, have a noncontingent love of self, and take presumptive control of others. They often behave with contempt toward those with whom they are involved. They see their own achievements in grandiose and inflated terms while devaluing the contributions of others. At the same time, these individuals have an extreme vulnerability to criticism or being ignored. When their superior position is challenged or their lack of perfection is demonstrated, their self-concept may, for a while, degrade to severe self-criticism (or they may engage in an outburst of rage). Without effective penetration of their defenses, however, individuals with NPD are pleased with themselves and

expect to be noticed and acknowledged as special (Benjamin, 1993, pp. 147–151).

Issues With Authority

Competent individuals with NPD are often in positions of authority themselves. If dealing with other authority figures, they are non-deferential, convivial or condescending, and presumptive of special treatment. They do not reveal any information derogatory to themselves and behave with self-righteous indignation when questioned. Lying is not difficult; concealment is a routine behavior. These individuals are unwilling to accept that society's limitations apply to them.

NPD Behavior

NPD behavior is usually haughty. These individuals behave in an arrogant, supercilious, pompous, and disdainful manner. They have a careless disregard for their own personal integrity and a self-important indifference to the rights or needs of others (Millon & Davis, 1996, p. 405). Yet, they can also show assertiveness, social poise, assurance, leadership potential, and achievement orientation (Wink, Costello, ed., 1996, pp. 153–154). Their ambition and confidence may lead to success, but their performance can also be impaired by their intolerance of criticism (DSM-IVô, 1994, p. 659). For all of their grandiosity, individuals with NPD are remarkably thin-skinned. They are easily offended and frequently feel mistreated (Golomb, 1992, p. 22). Individuals with NPD also experience boredom, dissatisfaction, and a lack of fulfillment and meaning in their work (Wink, Costello, ed., 1996, p. 149). It is problematic for these individuals to stay in long-term employment where responsibility for error or failure get harder and harder to obscure (Richards, 1992, p. 252).

Individuals with NPD do not believe that reciprocal social responsibilities apply to them. They expect others to serve them without giving much in return (Millon & Davis, 1996, p. 405). They are abrasive, abrupt, and lacking in gratitude (Beck, 1990, p. 244). They may engage

in
temper tantrums, verbal harangues, and emotional, physical, or sexual abuse because of their belief that others should be primarily concerned
with making them happy or comfortable. These individuals are particularly
apt to become resentful and contemptuous of anyone who tries to hold them
accountable for their exploitative, self-centered behavior (Beck, 1990, p.
244).

Sperry (1995, p. 114) notes that individuals with NPD are expansive and
inclined to exaggerate; they focus on images and themes and take liberties
with the facts. They use self-deception to preserve their own illusions.
They will do whatever is needed to reinforce their self-ascribed superior
status (Beck, 1990, p. 50). They are competitive, boastful, impatient, arrogant, and hypersensitive (Sperry, 1995, p. 114). Individuals with NPD
evidence an uneven morality and a readiness to shift values to achieve goals; they may engage in pathological lying (Akhtar, 1992, p. 69).

Affective Issues

NPD affect is generally nonchalant, imperturbable, and characterized by
feigned tranquility. This changes when individuals with NPD experience a
loss of confidence. Then they become enraged and may experience feelings
of shame and emptiness. If these individuals lose their narcissistic feelings of easy superiority, they become irritable, annoyed, and subject
to repeated bouts of dejection and humiliation (Millon & Davis, pp. 405-408).

Richards (1993, p. 249) notes that individuals with NPD frequently experience rage, indignation, and frustrated entitlement. Kernberg (1992,
pp. 21-22) suggests that hatred is the core affect of severe personality
disorders. He believes that the hatred derives from rage which, early in
life, served to eliminate pain but became useful, later in life, to eliminate obstacles to gratification. Beck (1990, p. 235) suggests that

individuals with NPD experience intense envy, fear, and rage. They are particularly angry when others do not accord them admiration or respect
(Beck, 1990,. p. 50).

NPD rage is more tolerable to these individuals than the shame and envy
that is associated with helplessness, a sense of ugliness, and impotence
(McWilliams, 1994, p. 172).

Defensive Structure

Individuals with NPD are trapped in a kind of perfectionism. They have unrealistic ideals for themselves; then they either convince themselves
that they have attained these ideals (the grandiose posture) or feel inherently flawed and a failure (the depressive posture) (McWilliams, 1994, p. 174).

The NPD illusion of superiority is a facet of a generalized disdain for
reality. These individuals feel unconstrained by rules, customs, limits,
and discipline. Their world is filled with self-fiction in which conflicts
are dismissed, failures redeemed, and self-pride is effortlessly maintained. They easily devise plausible reasons to justify self-centered
and inconsiderate behavior. Their memories of past relationships are often
illusory and changing. If rationalizations and self-deception fail, individuals with NPD are vulnerable to dejection, shame, and a sense of
emptiness. Then they have little recourse other than fantasy. They have an
uninhibited imagination and engage in self-glorifying fantasies. What is
unmanageable through fantasy is repressed and kept from awareness. As they
consistently devalue others, they do not question the correctness of their
own beliefs; they assume that others are wrong. The characteristic difficulties of individuals with NPD almost all stem from their lack of
solid contact with reality. If the false image of self becomes subtantive
enough, their thinking will become peculiar and deviant. Then their defensive maneuvers become increasingly transparent to others (Millon &

Davis, 1996, pp. 405-423).

Table of Contents

Treating the Narcissistic Personality Disorder

The Narcissistic Personality Disorder Coming Into Treatment

Individuals with personality disorders usually come for therapy with presenting issues other than personality problems -- most often 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).

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.

Medication Issues

Janicak, et.al. (1993, p. 519) are not aware of any drug treatment studies for NPD. Seiver suggests that there is data showing that the SSRIs have been effective in reducing the target symptoms of interpersonal sensitivity and reactivity (Sperry, 1995, p. 130). This may or may not be effective for clients with NPD. These individuals may also regard medication as an indication of personal defectiveness and be unwilling to be compliant (Ellison & Adler, Adler, ed., 1990, p. 59). Overall, medication for individuals with NPD would primarily address the symptoms of any co-occurring Axis I disorder.

Treatment Provider Guidelines

According to Kantor (1992, p. 10), personality disorders in general are composed mostly of abrasive and maladaptive traits that are favored over more adaptive traits (although there are adaptive traits within all personality disorders). Service providers must be able to validate individual clients, suggest adaptive change, and affirm adaptive behaviors without becoming overly responsive to the annoying qualities that characterize the personality disorder in evidence.

Among the most important qualities for service providers working with individuals with NPD are genuine nondefensiveness and noncompetitiveness (Stone, 1993, p. 276). Service providers must find a way to be comfortable with both the idealization and the critical denunciation of these clients. Working with individuals with NPD sometimes involves managing unreasonable demands, expectations or criticism. Their anger in treatment often comes from the clients' feeling that the service providers have failed to be sufficiently responsive to their need for affirmation, recognition or praise; over time, it is nearly impossible to avoid disappointing these clients. If the service provider responds negatively to the NPD self-aggrandizing or arrogance, even non-verbally, these individuals will pick up the criticism and what they experience as rejection (Rodin & Izenberg, Rosenbluth & Yalom eds., 1997, pp. 115-120).

For individuals with NPD, validation of their thinking and emotional experience is crucial to the growth of more adaptive skills (Rodin & Izenberg, Rosenbluth & Yalom, eds., 1997, p. 120). They may seem to bring into treatment an invulnerable armor of grandiosity, self-centeredness, exhibitionism, arrogance, and an inclination to devalue others. Even the depression beneath the arrogance is made up of narcissistic outrage and feelings of humiliation (Masterson, 1981, p. 30). Yet the psychological frailty is real and treatment for individuals with NPD must involve the issue of disillusionment (Rodin & Izenberg, Rosenbluth & Yalom, eds., 1997, p. 121). Service providers must confront clients with NPD with the aspects of reality they are denying, devaluing, or avoiding. With firmness and tact, service providers must confront NPD grandiosity, entitlement, and arrogance while remaining aware of the vulnerability these clients have to excruciating shame in response to perceived criticism (McWilliams, 1994, pp. 181-183). The process of treatment will involve the annoying NPD persistence in blaming others for their problems, adopting a position of superiority over treatment providers, and perceiving constructive confrontation as humiliating criticism (Millon & Davis, 1996, p. 422). Yet, service provider impatience, indignation, or counter-arrogance is non-productive and will result in treatment failure.

The need for tact and caution has to do with the tenuous quality of the relationship with clients with NPD. These individuals will flee any situation in which they experience their self-esteem as diminished. They run from their own mistakes and hide from people who might find out (McWilliams, 1994, p. 183). Clients with NPD do not balance their self-approval with an ability to see and accept their own defects. Learning to tolerate one's own faults must be modeled by the service providers (Benjamin, 1993, p. 157) via their apparent nonjudgmental, accepting, and realistic attitudes toward their own human imperfection and frailty (McWilliams, 1994, p. 182). Confrontation with individuals with NPD must be embedded in strong support (Benjamin, 1993, p. 157). It will, however, also need to be clear, direct, repetitive, and firm to breach

the
defenses used by clients with NPD.

Transference and Countertransference Issues

Service providers may initially be flattered and enjoy the company of clients with NPD. They then begin to experience a growing annoyance and
frustration that these individuals expect to feel better while the treatment provider actually does the work (Beck, 1990, p. 253). Helping
professionals can then either begin to feel devalued and work harder to
win their NPD clients' approval or become irritable, rejecting, or blaming.

Typical countertransference issues with clients with NPD are boredom, frustration and anger. Because these individuals are inclined to demand a
great deal and give very little, devalue others, and to be unable to respond to others with empathy, working with them is a very difficult process (Sperry, 1995, pp. 121-123). Another countertransference issue with these individuals is feeling obliterated and ignored as a real person. There is a sense, for treatment providers, that they do not quite
exist in the treatment room with the NPD client. The service providers can
then become sleepy, irascible, and unable to focus on the progress being
worked toward in treatment (McWilliams, 1994, p. 179).

Treatment Techniques

In assessing individuals for a possible personality disorder, Beck (1990,
pp. 608) suggests that service providers look for:

Statements such as: "I've always been this way."

Ongoing noncompliance with therapy.

Therapy that has come to a stop for no apparent reason.

Individuals that are unaware of the effect of their behavior on others.

Little indication that the clients are motivated to change.

The appearance that personality problems are natural and acceptable to

these individuals.
In the assessment process, individuals with NPD will usually provide information regarding:

their lack of awareness of the impact of their behavior on others;

their preference that others change their behavior toward the clients with NPD;

their wish to feel better without any indication that they may have to work to achieve that goal; and,

their self-acceptance that leaves little room for change.

These individuals seem to give the impression that the purpose of the interview is solely to endorse their self-promoted importance (Sperry, 1995, p. 121). However, they may have severely traumatic histories. Even if clients with NPD appear arrogant and powerful, insight oriented therapy may put them at risk for depression and suicidality as they experience their own lies about themselves.

Cognitive therapy tailors treatment of NPD to three basic components: grandiosity, hypersensitivity to criticism, and empathic deficits. These Individuals are seen as having dysfunctional beliefs about the self, the world, and the future. They regard themselves as special, exceptional, and justified in focusing on their own personal gratification at the expense of others. They expect admiration, deference, and compliance from others.
Their expectations of the future have to do with the realization of grandiose fantasies. They do not believe that other peoples' feelings are important. Their behavior is impaired by deficits in their capacity to cooperate with others and to engage in reciprocal interaction. They engage in excessively demanding and self-indulgent behaviors. Cognitive therapy conceptualizes NPD in terms of these dysfunctional beliefs and develops the treatment to address these issues (Beck, 1990, p. 238).

Interpersonal therapy addresses recognizing and blocking the patterns of entitlement, grandiosity, and envy of the success of others (Sperry,

1995,
pp. 126–127). Masterson (1981, pp. 74–75) suggests that the NPD idea that
perfection provides protection and life must be trouble-free and perfect
should be addressed in the treatment process.

Treatment Goals

Adler (Adler, ed., 1990, pp. 26–28) proposes that treatment goals for all
personality disorders include:

preventing further deterioration;

establishing or regaining an adaptive equilibrium;

alleviating symptoms;

restoring lost skills; and,

fostering improved adaptive capacity.
Treatment interventions teach more adaptive methods of managing distress,
improving interpersonal effectiveness, and building skills for affective
regulation. Goals may not necessarily include characterological
restructuring. The focus of treatment should be adaptation, i.e., how
these individuals respond to the environment.

Beck (1990, p. 249) also believes that NPD treatment needs to focus on
increasing behavioral responsibility, decreasing cognitive distortions and
dysfunctional affect, and developing new attitudes.

There is substantial practicality to this approach as many individuals
with NPD will come for treatment only under considerable duress. It may be
legal involvement or a crisis at home or work, but once the pressure is
removed or the pain of the event lessened, these individuals usually leave
treatment without any desire to change essential characterological
attributes. Sperry & Carlson (1993, p. 320) note that most individuals
with NPD come into treatment with the goal of having their narcissistic
wounds soothed rather than seeking change.

While the apex of personality development, according to Masterson

(1981,
p. 185), is to develop the capacity to take full responsibility for self
-- wishes, behavior, and consequences for behavior -- more adaptive functioning can actually be a substantial success in treatment, and may,
over time, lead to a more fundamental change in attitude and behavior.

Should individuals with NPD be ready to work toward an overall level of
improved functioning, they may be willing to develop the adaptive qualities of their personality style rather than remain locked into personality-disordered functioning (Sperry, 1995, pp. 7-11). According to
Oldham (1990, pp. 79-84), the NPD personality style is that of self-confidence. These non-personality disordered individuals have self-respect; they believe in themselves and their abilities; they are ambitious; they are able to take advantage of their own strengths and abilities; they can visualize themselves as successful; they have poise
and self-possession; they can hear and accept criticism. They are outgoing, high-energy, competitive people. They are instinctively political and adept at understanding power structures. They may be gifted
leaders and are able to work comfortably and effectively with others.

Work with individuals with personality disorders should not attempt to make them what they are not and can never be. Since all personality disorders have strengths and at least positive potential, treatment should
aim at the most adaptive expression of that particular personality style.
This approach would be most in harmony with individual clients and have
the greatest potential for success.

Table of Contents

Dual Diagnosis Treatment:
Treating The Addicted Narcissistic Personality Disorder
Cluster B: Incidence of Co-Occurring Substance Abuse Disorders

Cluster B has the highest incidence of co-occurring substance abuse disorders of the three DSM-IV personality disorder clusters (Nace, O'Connell, ed., 1990, p. 184).

Freud said that drugs can give pleasure and a greatly desired degree of
independence from the external world; drugs allow withdrawal from the

pressures of reality (Khantzian, Halliday, & McAuliffe, 1990, opening page). Individuals with NPD will be attracted to drugs that support their inflated self-image and permit them to evade a reality they dislike. Independence from the external world (and its tenacious reality-based pressures) allow these individuals to be remain unaware of their failures, rejections, limitations, and inability to self-regulate. Drugs become an alternative to living life on its own terms.

Khantzian, et. al. (1990, p. 3) view the treatment of any character disorder as the road to recovery from addiction. However, their approach also demands continued attention to and concern about maintaining abstinence and avoiding relapse. Addiction becomes a disorder in its own right and must be addressed directly. Nevertheless, the treatment of personality disorders can lead to profound change in the personality disordered individual's experience of self and the world, which, in turn, can positively affect recovery from addiction.

Individuals with NPD are vulnerable to drug and alcohol abuse and addiction:

for the feelings of dominance and well-being they provide (Benjamin, 1993, p. 160);

for the experience of wholeness and vitality (Rodin & Izenberg, Rosenbluth & Yalom, eds., 1997, p. 108);

as a mistaken and erroneous way to achieve significance and avoid a painful clash with reality (Sperry & Carlson, 1993, pp. 420-421);

as part of the overall narcissistic pattern of self-involvement and self-indulgence (Beck, 1990, p. 240);

because of their need for a high level of stimulation (Richards, 1993, p. 240);

to provide immediate relief from personal discomfort and a sense of self-importance and power (Beck, 1990, p. 240);

to sooth unacknowledged tensions created by hypersensitivity to evaluation (Beck, 1990, p. 240).

The belief that they are unique and special serves to insulate these individuals from the recognition that they have developed a reliance on drugs. It also allows them to believe that they can escape the negative effects of addiction; they can easily quit using chemicals (Beck, 1990, p. 240). They maintain the grandiose belief, sometimes in extraordinary circumstances, that they are in charge of their addiction (Richards, 1992, p. 239). The NPD grandiosity, crucial in maintaining addiction, is the assumption of an exalted but impossible privileged status. The grandiose feelings are expressed as being exempt from both the consequences of behavior and the laws of nature (Salzman, Mule, ed., 1981, p. 344).

Drugs of Choice for the Narcissistic Personality Disorder

Individuals with NPD are vulnerable to drug and alcohol abuse or addiction because there are drugs which support an inflated sense of self and drugs that interrupt or moderate feelings of depression and low self-esteem. Most of these individuals will use drugs that enhance their feelings of vigor, power, or euphoria. Cocaine is very effective for this goal. Individuals with NPD, to ward off unwanted intrusions of unpleasant reality, use denial, flight, and overcompensation supported by increased activity, overproductivity, and grandiosity. Use of these defenses can result in increased isolation. These individuals will use alcohol and other sedatives to facilitate this isolation. There are some individuals with NPD who prefer the autistic stimulation of hallucinogens (Richards, 1993, p. 253).

Another factor in looking at the NPD drug of choice is the consummate skill required to manage the drug situation (including dealing) and the centrality to others that drug dealing fosters. It is possible that these activities may be more rewarding to individuals with NPD than the drug use itself (Richards, 1993, p. 253).

Dual Diagnosis Treatment for the Narcissistic Personality Disorder

Richards (1993, p. 278) suggests that treatment failures for the dually

diagnosed are often a result of failure to consider the function of the addiction, including the drug of choice, within the context of the psychopathology dominant in the individual. Salzman (Mule, ed., 1981, pp. 346-347) believes that the inner forces that initiate and sustain addiction are immaturity and inappropriate, magical coping techniques. Dual diagnosis treatment must involve recognition of the tendencies that foster addictive behavior, i.e., immaturity, escapism, and grandiosity. New ways must be learned for dealing with feelings of powerlessness and helplessness other than compulsivity.

Individuals with NPD will be quite uncomfortable with the view of themselves as addicts. In fact, these individuals are prone to hidden or secret addictions because of the contradiction such behavior has for the image they wish to project to others. The fear of detection by admirers can be a source of significant motivation for abstinence. However, their tendency toward denial, rationalization, and fantasy provide very strong support for drug use and denial of loss of control (Richards, 1993, p. 253).

Addiction can be an attempt to cope with fear without facing it squarely. A function of addiction can be avoidance -- a tactic of escape. The cost of addiction varies only with the magnitude of the compulsion; it is a form of servitude. The aim of treatment is to untangle a web of self-deceit around avoidance, escape, and denial (Weinberg, 1993, pp. 6-64). For individuals with NPD, the idea of servitude and the implications of the fear associated with escape behaviors may be unpleasant enough to allow them to consider abstinence as symbolic of their personal strength. This view of themselves will meet their psychological need to feel superior.

Successful dual diagnosis treatment for individuals with NPD will need to include: encouragement of appropriate dependency (people rather than drugs), development of tolerance for sad or uncomfortable affect, increased acceptance of personal limitations, and emotional connection to others (Richards, 1993, p. 254). Twelve Step involvement can be quite positive for these individuals. In AA entitlement is confronted with

humor
and insight. Generous support is offered, but there is gentle pressure to
confront the problem (Benjamin, 1993, p. 160).

Individuals with NPD are particularly prone to relapse. They are inclined
to be free of the fear of relapse or believe that they can re-engage in
controlled use because of what they have learned about addiction. Once in
relapse, individuals with NPD have significant trouble returning to
treatment because of the shame and humiliation (Richards, 1993, p. 254).
Part of the positive treatment impact of relapse for these clients is the
acceptance of human limitations both in the power of the addictive process
and the need for help from others to remain abstinent.

Direct confrontation is usually needed to breach the strong defenses of
the dually diagnosed individual with NPD. However, once confrontation
becomes effective, the possibility of severe depression is significant and
may require treatment. Abstinence can be a requirement for treatment and
use should result in termination. Both stances reinforce that limitations
do apply to these individuals and their behavior can have negative
consequences.

Table of Contents

Sharon C. Ekleberry, 2000

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