

Narcissistic Grandiosity and Narcissistic Vulnerability in Psychotherapy

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This article briefly summarizes the empirical and clinical literature underlying a contemporary clinical model of pathological narcissism. Unlike the DSM Narcissistic Personality Disorder (NPD), this clinical model identifies and differentiates between two phenotypic themes of dysfunction—narcissistic grandiosity and narcissistic vulnerability—that can be expressed both overtly and covertly in patients' ways of thinking, feeling, behaving, and participating in treatment. Clinical recognition that narcissistic patients can and often do present for psychotherapy in vulnerable states of depression, anxiety, shame, and even suicidality increases the likelihood of accurate diagnosis and effective treatment planning. This article provides case examples derived from psychotherapies with narcissistic patients to demonstrate how narcissistic grandiosity and narcissistic vulnerability concurrently present in patients who seek treatment.

Keywords: narcissism, grandiosity, vulnerability, psychotherapy

As a result of the multiplicity of meanings associated with narcissism across psychology and psychiatry, there is no gold standard with which to synthesize clinical observations and findings. Relying solely on the criteria for Narcissistic Personality Disorder (NPD) found in the *Diagnostic and Statistical Manual of Mental Disorders-5* (DSM-5; APA, 2013) for diagnosis and treatment planning is unsatisfactory for many reasons. These include NPD exhibiting the lowest prevalence rate of any of the DSM personality disorders, which is inconsistent with the frequency of narcissistic diagnosis found in clinical practice (Cain, Pincus, & Ansell, 2008), the DSM criteria's narrow emphasis on grandiosity and its limited fidelity to actual clinical phenomenology (Pincus, 2011), and a lack of clinical utility and treatments for NPD (Dhawan, Kunik, Oldham, & Coverdale, 2010).

Moving beyond NPD, reviews of the clinical, psychiatric, and social/personality psychology literature clearly paint a broader portrait of pathological narcissism encompassing two phenotypic themes of dysfunction, *narcissistic grandiosity* and *narcissistic vulnerability* (Cain et al., 2008; Pincus & Roche, 2011). The lack of sufficient vulnerable DSM NPD criteria is now a common criticism (Miller, Widiger, & Campbell, 2010; Ronningstam, 2009). The overly narrow construct definition of pathological narcissism found in DSM NPD limits its clinical validity and utility, as narcissistic patients are more likely to seek treatment when they are in a vulnerable self-state (Ellison, Levy, Cain,

Ansell, & Pincus, 2013). Thus, a clinician relying solely on DSM NPD diagnostic criteria may fail to recognize pathological narcissism in a presenting patient.

Three suggestions for revising the DSM diagnosis of NPD have appeared in the literature. One suggestion is to revise the DSM criteria to include features reflecting narcissistic vulnerability (e.g., Ronningstam, 2011). An alternative proposal would consider narcissistic vulnerability a specifier for NPD diagnoses (e.g., NPD with vulnerable features) similar to specifiers used for other diagnoses (Miller, Gentile, Wilson, & Campbell, 2013). A third alternative considers pathological narcissism a facet of general personality pathology representing a core feature of all PDs rather than a specific PD diagnosis (Morey & Stagner, 2012). Research is required to resolve this nosological debate; and, all of these proposals require that diagnosticians and psychotherapists recognize the clinical presentation of pathological narcissism in their patients.

This article focuses on describing the clinical presentation of pathological narcissism. First, we briefly summarize the literature supporting the broader conceptualization of pathological narcissism, and then we present case examples drawn from psychotherapies with narcissistic patients in a community mental health outpatient clinic to demonstrate how narcissistic grandiosity and narcissistic vulnerability concurrently present in patients seeking treatment.

Narcissistic Grandiosity and Narcissistic Vulnerability

To the layperson, narcissism is most often associated with arrogant, conceited, and domineering attitudes and behaviors, which are captured by the term *narcissistic grandiosity*. This accurately identifies some common expressions of maladaptive self-enhancement, disagreeableness, and lack of empathy associated with pathological narcissism. However, an emerging contemporary clinical model of pathological narcissism (Pincus & Lu-

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kovitsky, 2010; Roche, Pincus, Lukowitsky, Ménard, & Conroy, 2013) combines grandiosity with clinically important regulatory impairments that lead to self, emotional, and behavioral dysregulation in response to ego threats or self-enhancement failures (see Figure 1).

Needs for admiration and motives to self-enhance are normal aspects of personality, but they become pathological when they are extreme and coupled with impaired regulatory capacities (Pincus, 2013). It is normal for individuals to strive to see themselves in a positive light and to seek experiences of self-enhancement, such as successful achievements and competitive victories. Most individuals manage these needs effectively, seek out their gratification in culturally and socially acceptable ways and contexts, and regulate self-esteem, negative emotions, and interpersonal behavior when disappointments are experienced. In contrast, pathological narcissism involves impairment in the ability to regulate the self, emotions, and behavior in seeking to satisfy needs for recognition and admiration. Put another way, narcissistic individuals have notable difficulties transforming narcissistic needs (recognition and admiration) and impulses (self-enhancement motivation) into mature and socially appropriate ambitions and conduct (Roche et al., 2013).

In this model, grandiose symptoms consistent with DSM NPD exist in tandem with impaired regulation, or *narcissistic vulnerability*, reflected in experiences of anger, envy, aggression, helplessness, emptiness, low self-esteem, shame, social avoidance, and even suicidality. Evidence for the two phenotypic themes of narcissistic grandiosity and narcissistic vulnerability comes from theory and research in clinical psychology, psychiatry, and social/personality psychology (Cain et al., 2008; Pincus & Roche, 2011); and in recent years, recognition of both grandiose and vulnerable themes of narcissistic dysfunction has increasingly become the norm (e.g., Kealy & Rasmussen, 2012; Ronningstam, 2011; Russ, Shedler, Westen, & Bradley, 2008; Wright, Lukowitsky, Pincus, &

Conroy, 2010). Narcissistic grandiosity involves intensely felt needs for recognition and admiration giving rise to urgent motives to seek out self-enhancement experiences. When this dominates the personality, the individual is concomitantly vulnerable to increased sensitivity to ego threat and subsequent self, emotion, and behavioral dysregulation (i.e., narcissistic vulnerability).

Overt and Covert Narcissism

The terms overt and covert narcissism are frequently used in the psychological literature. Unfortunately, many incorrectly associate overt expressions of narcissism exclusively with grandiosity and covert expressions of narcissism exclusively with vulnerability. There is no empirical support for these linkages. DSM NPD criteria as well as items on various self-reports, interviews, and rating instruments assessing pathological narcissism include a mix of overt elements (behaviors, expressed attitudes, and emotions) and covert experiences (cognitions, private feelings, motives, needs). Our clinical experience with narcissistic patients indicates they virtually always exhibit both covert and overt grandiosity and covert and overt vulnerability. As we depict in Figure 1, the distinction between overt and covert expressions of narcissism is secondary to phenotypic variation in grandiosity and vulnerability.

Case Examples

In the following cases,¹ we first provide an example of a patient meeting DSM NPD criteria and then provide two examples of patients we diagnose as suffering from pathological narcissism, but may not meet DSM criteria because of their pronounced vulnerability. In portraying these latter cases, we opted to present their vulnerable characteristics first, followed by their grandiose features. We chose this approach because narcissistic patients who seek outpatient treatment in community mental health centers typically present in dysregulated states in which more vulnerable symptoms are prominent and grandiosity is only detectable later in treatment after patient stabilization. All of these cases portray patients with severe personality pathology. However, it should be noted that pathological narcissism is associated with a range of impairment and can also be seen in higher-functioning patients.

Case 1: Mr. A

Mr. A was a single male in his late 30s who lived alone, met criteria for DSM NPD, and presented at the clinic twice for treatment within a 2-year period. He saw two different therapists and unilaterally terminated both therapies after 7 sessions and 18 sessions, respectively. He was a disabled veteran who reported feeling angry toward and envious of the VA, neighbors, women, and society as a whole. He also reported feeling very mistreated and disrespected by most other people and institutions. Mr. A reported that he felt his parents were cold and aloof, emphasizing that they had not helped him resolve highly competitive feelings he developed toward his older brothers. He recalled being treated frequently with strong allergy medicines that left him foggy and

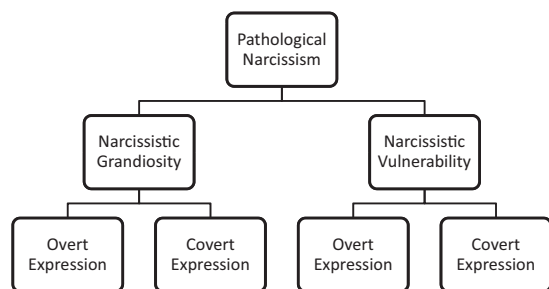


Figure 1. A contemporary clinical model of narcissism. Adapted from "Pathological narcissism and Narcissistic Personality Disorder," by A. L. Pincus and M. R. Lukowitsky, 2010, *Annual Review of Clinical Psychology*, 6, p. 431. Copyright 2010 by Annual Reviews. Reprinted/adapted with permission.

¹ Identifying features and case material have been altered to protect patient confidentiality.

detached from others. As an adult Mr. A's contingent self-esteem and unresolved competitive needs appeared compensated for by a distorted self-view that he was far more capable, powerful, and deserving than reality suggested.

In treatment, Mr. A's narcissistic vulnerability was identifiable through the dominant affects of unrelenting resentment, anger, and envy, which he clearly could not regulate effectively. However, his therapists' efforts to empathize with his emotions and developmental history were consistently met with increased grandiosity and denigration. In therapy he regularly belittled, mocked, and challenged therapists, "I know I'm narcissistic and there's nothing you can do about it," "You can do your empathy thing, but it will have no effect on me," "You're just a trainee, you don't know enough to help me," and "I'm only here to get medication because the VA requires too much paperwork and makes me wait too long." In addition to deriding his therapists, Mr. A. regularly threatened people he found parked in his apartment's assigned parking space and fantasized to his therapist about buying a gun and shooting the next person who parked there. A clinically relevant fact to note is that Mr. A did not drive or even own a car.

Mr. A exhibited chronic grandiosity and entitlement throughout his two therapies and never acknowledged receiving anything beneficial from them before unilaterally terminating treatment. Understandably, both his therapists felt deskilled and beat up in sessions. Countertransference feelings of incompetence and inutility can be useful in recognizing pathological grandiosity, as it may signal a narcissistic dynamic where the therapist cannot be right, or good enough, or know something about the patient that the patient doesn't know him- or herself, because these experiences threaten the patient's idealized self-concept.

Although Mr. A expressed simmering resentment, anger, and envy, he did not respond positively to therapeutic efforts to process these feelings, never sought help for them, and never wanted support from his therapists. This patient is among the very few we have seen who meet DSM NPD criteria in an obvious and immediately apparent way, and voluntarily seek treatment. In fact, it may very well be that Mr. A's main motivation for seeking help from the clinic was to by-pass whatever he found intolerable about receiving treatment from the VA. This is a cycle that might repeat itself with numerous treatment providers.

Case 2: Mr. B

Vulnerability. Mr. B was a 40-year-old single, college-educated male living with his parents after discharge from his most recent hospitalization. He presented for therapy as socially isolated with impaired intimacy. He had no friends or relationships except with his parents, had difficulty maintaining employment as a dishwasher, and expressed pessimism about his ability to improve his life. He wished to pursue permanent disability status and was interested in moving to a residential facility for the mentally ill. His most pronounced symptom was an empty depression characterized by agitation and anhedonia but with an absence of sadness or melancholia. Mr. B was chronically suicidal and described waking up each day feeling "horrified" he was still alive. Early in treatment, he would commonly respond to therapist questions with long latencies during which he lowered his head into his hands and repeatedly rubbed his head in anguish before responding with one or two words or "I don't know." Mr. B tried many different

antidepressants with minimal effects and was admitted to the hospital 3 times in a 12-month period, once for a long course of ECT that was similarly ineffective. Clearly Mr. B's initial presentation was one of a vulnerable and anguished patient, and he would be appropriately diagnosed with a mood disorder, but he would not meet criteria for DSM NPD.

Grandiosity. Over the course of psychotherapy, the therapist learned about several other features of Mr. B's thoughts, feelings, and behaviors that suggest narcissistic grandiosity. But unlike the first case, these expressions were at first subtle or unacknowledged by the patient and they oscillated with more depressive states. Mr. B was a skilled keyboard player with a sizable home recording studio. But the instruments lay untouched and he reported no intrinsic pleasure in playing them as he only enjoyed it when people paid to hear him play. He tried playing with a few local bands, but none were "serious enough" or "talented enough" and he even devalued his own musical interests as too "flawed and disappointing" to pursue. Mr. B also used to be an avid bicyclist. However, after excitedly purchasing a new and high-quality model, Mr. B became obsessed with the various noises the bicycle made while riding it. He was unhappy and felt it was too noisy. He tried to stop the offending noises without success. With the encouragement of his therapist, Mr. B tried for some time to ride the bike despite his disappointment over its imperfections. However, like playing music, he eventually lost interest in riding his bike and felt depressed about that as well.

Mr. B also felt that daily responsibilities like buying groceries, finding a job, balancing his checkbook, filling out forms, and paying taxes were a "hassle" and he should not have to do them. In fact, he continued to rely on his parents to do most of these things for him. When he was living in his own apartment, he lived off of a trust fund and his mother still balanced his checkbook and took him on a weekly shopping trip. When the trust fund ran out, he strategically took an overdose to ensure his mother would find him when she arrived for their weekly grocery shopping. Despite all of his parents' help (for better or worse), in therapy he expressed resentment toward them for aging and having decreasing resources. For example, he complained bitterly that his mother took much longer to balance his checkbook than she used to and he was disappointed when they could not immediately buy him a car. The therapist learned the main reason Mr. B could not hold a job was because he resented the lack of control over his schedule. He would angrily quit jobs when asked to change his schedule to accommodate other employees' vacations or even his employers' changing needs. He had no friends because he saw relationships as meaningless and insisted he "can't tolerate listening to other people's shit."

Mr. B was very depressed at times, but recognition that it was attributable to his personality pathology improved his treatment. Important features of his presenting mood symptoms can alert therapists to pathological narcissism. First, his depression was characterized by emptiness, nihilism, and agitation rather than sadness. Ultimately, his perfectionism and grandiose expectations of self and others destroyed his ability to experience positive reinforcement from any social, occupational, or recreational activities. Second, depression and suicidality were exacerbated by resentments and disappointments over entitled expectations (depleted trust fund, decreasing parental resources). Third, his mood symptoms did not respond to medication or ECT. Therapist coun-

tertransference was also informative in identifying narcissism. Although Mr. B reported and exhibited significant anguish, his therapist experienced increasing impatience over his chronic passivity and externalization of blame. Ultimately she realized that he was exhibiting entitled expectations that someone (parents, therapist) or something (medication, ECT, social assistance) should solve his problems rather than taking responsibility for working hard in therapy. By recognizing the phenomenology of Mr. B's depressive symptoms and narcissistic themes in her countertransference, the clinician better understood the patient's mood disorder diagnosis in the context of his pathological narcissism.

Case 3: Mr. C

Vulnerability. Mr. C was a 38-year-old college educated male living in the basement apartment of his parent's home after his marriage ended in divorce. He presented as socially isolated, socially anxious, and fearful of intimacy. Mr. C described increasing anxiety when interacting with others, and he had no friends and was unemployed. Both of his parents worked full time. Mr. C spent most of his time in the basement apartment, only venturing upstairs when his parents were gone. He was deeply ashamed of his current circumstances, had difficulty communicating his needs directly, and coped with this via withdrawal. When therapy began, he explained that he was currently unemployed because he "gets too emotional" at work. Mr. C complained that social exposure elicited significant shame if he had to disclose his unemployment status and living situation. Like Mr. B., he also reported an empty depression characterized by anhedonia, feelings of worthlessness, and suicidal ideation, but no sadness. Mr. C presented as a vulnerable and ashamed patient and he would be appropriately diagnosed with an anxiety or mood disorder, but he would not meet criteria for DSM NPD.

Grandiosity. Over the course of psychotherapy, the therapist learned about several other features of Mr. C's thoughts, feelings, and behaviors that suggest narcissistic grandiosity. Mr. C often lied about his current life situation to others when he was in public, indicating he was "building a new restaurant in the next town over." Early in therapy, Mr. C successfully returned to work in retail sales, a job he reported to be "exceptionally" good at. Soon after, the retailer hired another salesperson. Mr. C resented this and instigated a physical altercation with the new employee the first day he arrived at work. Mr. C was subsequently fired. It also became clear that Mr. C expected special treatment without commensurate skills or achievements. He told his therapist that he would feel better about trying to get another job if he were just paid a dollar more an hour than everyone else. After actually obtaining another position, Mr. C was fired on his first day of work for requesting a raise after only 1 hour on the job. Rather than mobilizing toward independent living, he commonly retreated into grandiose fantasies about being a benevolent company owner who was adored by his employees.

Mr. C also experienced angry affects as a result of his entitled expectations. In therapy he reported that when his parents were at home he would retreat to the basement feeling angry that they intruded on his space and time. When alone in the house, he experienced it as "his house" and reported became particularly enraged one day when his father interrupted this fantasy by unexpectedly coming home from work for lunch. Mr. C's parents asked

him to do chores around the house and property, which he reluctantly tended to. Although he lived in the basement apartment rent free, in therapy he expressed resentment over these requests and was critical of his parent's inability to do the chores themselves. Although he presented as ashamed, anxious, and depressed, Mr. C routinely externalized blame for his problems to his parents, co-workers, therapist, even the weather.

Many features of Mr. C's presentation are similar to the prior case. His depression was characterized by emptiness and agitation rather than sadness. His grandiose expectations of self and others impaired his social and occupational adjustment. Finally, his depression and suicidality were exacerbated by resentments and disappointments over entitled expectations (chores, favored employee status). Also consistent with the prior case, Mr. C's therapist experienced an increasing impatience over his chronic passivity, externalization of blame, and entitled expectations that others should be more tolerant and understanding. Unlike the prior case, Mr. C's perfectionistic intolerance of showing others any flaws or needs led to greater social anxiety. He also retreated into grandiose fantasies to cope with his isolation and negative affects. Thus he often avoided looking at the reality of his circumstances in session and instead reveled in his fantasies to convey that he was a good son, a good employee, and someone on the verge of accomplishing something great if only the conditions were right.

Conclusion

This article aims to provide researchers, diagnosticians, and therapists with clinical examples of pathological narcissism as it presents in treatment seeking patients. The contemporary clinical model of narcissism includes the two themes of narcissistic grandiosity and narcissistic vulnerability that often are concurrently expressed in patients. Treatment-seeking narcissistic patients will often initiate contact with providers when they are in a more symptomatic, vulnerable state because narcissistic grandiosity inhibits treatment utilization (Ellison et al., 2013). Such patients' grandiosity typically emerges as the therapeutic relationship develops. Thus, reliance on DSM NPD criteria at intake may well lead to a prominent diagnostic omission that should be rectified quickly for effective treatment planning.

Those patients who do exhibit significant pathological narcissism typically require a therapy that contextualizes their symptoms within their personality pathology. Prominent features of mood and anxiety disorders can alert therapists to pathological narcissism. In patients with significant pathological narcissism, depressed mood is characterized by emptiness and agitation but not sadness. Additionally, their reports of mood and anxiety symptoms are typically infused with resentment, anger, envy, and shame. Finally, clinicians should recognize the perpetuating influences of entitled expectations and perfectionism on mood and anxiety symptoms. Perfectionism in narcissism can be particularly pernicious, leading to both lack of positive reinforcement from occupational, social, and recreational activities and social withdrawal to hide an imperfect self. Therapists' countertransference reactions are also helpful in diagnosing pathological narcissism (Gabbard, 2009). Common reactions to grandiosity and vulnerability include feeling devalued and incompetent, impatient and exploited, or inhibited and fearful of wounding a hypersensitive patient. When clinicians experience such feelings despite the patient presenting

as highly depressed or anxious, it may indicate the presence of pathological narcissism. Recognizing the clinical phenomenology of narcissistic grandiosity and narcissistic vulnerability, and their associations with mood and anxiety symptoms and suicidality, can improve the clinical utility of diagnosing pathological narcissism (Pincus, Roche, & Good, in press) and lead to promising new treatment approaches (Ogrodniczuk, 2013).

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