Australian Clinical Psychologist
ISSN 2204-4981

Volume 3 ◆ Issue 1 ◆ Article no. 008

Opinion Piece

Therapist Stigma towards Narcissistic Personality Disorder: Lessons Learnt from Borderline Personality Disorder

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Abstract: The aim of this paper is to (a) provide a framework to understand and formulate the context of therapist stigma towards narcissistic personality disorder (NPD); and (b) comment on possible avenues for enhancing empathy, treatment outcome, and therapist resilience. In particular, we propose a crucial role for modern integrative forms of therapy, drawing on object relations and emotion-focused approaches that foster understanding of the developmental origins of NPD. This paper argues that increased discourse among clinical psychologists about uncomfortable countertransference would aid the de-stigmatisation of NPD, and likely improve treatment opportunities and outcomes for patients.

Keywords: Personality disorders, stigma, therapist factors, narcissism

Introduction

Patients with personality disorders have historically encountered significant stigma. However, increasingly therapists are replacing stigmatising labels (e.g., 'unstable' and 'manipulative') with non-judgemental descriptions (e.g., 'dysregulated,' or 'unskilful'). Despite this trend, narcissistic personality disorder (NPD) remains a highly stigmatised disorder, likely due to the challenges faced by therapists in treatment (e.g., becoming the object of narcissistic rage or devaluation), which evoke strong countertransference. This paper encourages therapists to engage in increased discourse about these uncomfortable countertransference reactions in a non-judgmental way. We argue that increased understanding of these reactions in the context of trauma-informed case conceptualisations could aid the de-stigmatisation of NPD pathology and improve therapist resilience and patient treatment outcome.

Therapists need effective supervision and refined case formulation skills to buffer unhelpful countertransference and maintain a working alliance conducive to progress and change for the patient with NPD. We propose that modern integrative forms of therapy, drawing on object relations, Gestalt, and emotion-focused approaches, such as schema therapy (Young, Klosko, & Weishaar, 2003), provide an avenue through which the therapist can cultivate a de-stigmatising, resilient, and effective therapeutic space for the patient with NPD.

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The Comparison of Borderline Personality Disorder

Due to its historical context of therapist stigma and the cultural shift within the psychological community to reduce this stigma over the last two decades, borderline personality disorder (BPD) serves as an illustrative comparison, providing insights into the possible pathways for reducing the stigma of NPD. A PsychInfo database search for *'borderline personality disorder'* OR *'borderline'* AND *'stigma'* OR *'prejudice'* results in 97 papers, 20 of which explore stigma towards borderline personality disorder (BPD; e.g., Aviram, Brodsky, & Stanley, 2006; Ferguson, 2016; Lam, Salkovskis, & Hogg, 2016). In direct comparison, a search for *narcissistic personality disorder* OR *narcissism* AND *stigma* OR *prejudice* elicits 56 papers, none of which explore stigma towards NPD. This is significant given that therapist stigma can impact treatment outcome and prognosis (Ferguson, 2016; Sheehan, Nieweglowski, & Corrigin, 2016).

Not altogether dissimilar to individuals with NPD, individuals with BPD can be challenging, emotionally labile, impulsive, struggle to control anger, and violate professional boundaries, generating countertransference that if left unexplored, can become therapeutically counterproductive. These features have historically evoked stigmatising views from therapists that patients are manipulative, undeserving of sympathy, in control of destructive behaviours, and undeserving of health care resources (Lewis & Appleby, 1988).

However, over the last two decades, there has been a decrease in stigma towards BPD. Perhaps one of the instrumental influences to increasing empathy and shifting the perception that BPD was 'untreatable' was the wide-spread dissemination of Marsha Linehan's dialectical behaviour therapy (DBT; Linehan, 1993). This offered an accessible and empirical treatment that acknowledged the impact of developmental trauma, utilised a supportive team consultation approach, and was promoted by a charismatic Linehan, who offered straightforward explanations and skills (Gunderson, 2009).

This serves as an interesting comparison to NPD, as both disorders demonstrate significant challenges to treatment, have origins rooted in developmental trauma, and evoke strong countertransference reactions. We propose that increased insight into the developmental origins of NPD, increased supportive consultation to explore countertransference, and a focus on improving empirical research and treatment models may similarly mitigate NPD stigma.

A De-stigmatizing Conceptualization of Narcissistic Personality Disorder

Patients with NPD are challenging because they believe themselves superior to others, struggle to admit faults, ignore the effect of their actions on others, and dislike honest feedback (Levy, Chauhan, Clarkin, Wasserman, & Reynoso, 2009). Schema therapy, in particular the schema mode model (Young et al., 2003), may provide a valuable therapeutic framework to formulate NPD behaviour as painful pathology, rather than as individual failing (Behary & Dieckmann, 2013).

Schema therapy provides a particularly compassionate perspective on the development of NPD and cultivates reflexive responding through an understanding of the function of challenging behaviour in session. According to the theory, schemas – the constellation of dysfunctional thoughts, feelings, and behaviours that affect the patient in adult life – have origins in unmet childhood needs (Young et al., 2003). The schema mode approach encourages formulation of the patients' over-

compensatory coping modes (e.g. 'self-aggrandising' or 'bully and attack' modes) as a way of coping with the painful activation of a vulnerable, lonely, or abandoned part of himself (the 'child modes').

Common early experiences of individuals with NPD involve caregivers who were intolerant of vulnerability, emotional experiences, and poor performance, whilst at the same time may have overly indulged the child or provided inadequate limits for inappropriate behaviour (Behary & Dieckmann, 2013). This emotional deprivation coupled with a sense of entitlement leaves the lonely child seeking possessions and status as a substitute for meaningful connection (Behary & Dieckmann, 2013).

It is common for therapists to experience their own schema activation or countertransference in response to narcissistic grandiosity or devaluation (Behary & Dieckmann, 2013). Defensive responses to either 'give in' or 'retaliate' by devaluing the patient in return are likely to re-enact familiar behavioural patterns for the patient with NPD, which serve only to strengthen their use of unhelpful coping modes.

Whilst, a detailed exploration of the therapeutic significance of transference and countertransference related to patients with NPD is beyond the scope of this paper, Table 1 depicts a brief overview of the most common countertransference experiences.

Table 1
Common Countertransference Reactions of Therapists Treating Patients with NPD

Patient experience	Observable behaviour	Common therapist countertransference
Over-compensation to avoid a sense of vulnerability.	Idealisation of the self or expression of superiority.	Admiring, disengaged, bored, resentful, inadequate, or frustrated.
	Idealisation or admiration of the therapist.	Pleased, sense of being special, overwhelmed, or feeling manipulated.
	Devaluation or contempt of the therapist.	Inadequate, sense of failure, dread, resentment, hurt, criticised, overwhelmed, angry, anxious, an urge to devalue in return, or try harder to please.
Avoidance of uncomfortable emotions.	Avoidance of emotions with self-stimulating or self-soothing activities (e.g., gambling, alcohol, risk-taking, grandiose fantasising, binge eating, or excessive dedication to work).	Anxious, critical, disengaged, frustrated, helpless, overwhelmed, or feeling stuck.
Activation of rage when vulnerability threatens to surface.	Rage and uncontrolled aggression.	Anxious, afraid, overwhelmed, 'walking on egg-shells,' confused, mistreated, angry, resentful, urge to retaliate, or urge to withdraw.

Therapists who work with NPD are commonly faced with over-compensation and heightened anger during their sessions (Kealy & Ogrodniczuk, 2011). Experiences of devaluation and contempt can evoke dread and resentment, whilst experiences of rage can evoke fear or a sense of 'walking on eggshells.' Therapists, in turn, often employ their own coping defences to avoid this discomfort, such as, over-compensation strategies (e.g., increased attempts to please, retaliation) or avoidance strategies (e.g., avoid calls, refer on; Kealy & Ogrodniczuk, 2011).

It is important for therapists to cultivate an open and non-judgemental curiosity to enhance awareness of their experiences and better understand the developmental origins of NPD pathology, to increase personal resilience and avoid acting in ways that hinder treatment (Kealy & Ogrodniczuk, 2011). Counter-transference can be a useful tool to understanding the inner experience of a patient, who does not yet have the capacity to verbalize their inner world. For example, therapist devaluation may be a patient's attempt to use projection to avoid internal shame that developed as the result of early hyper critical parental messages. Therefore, if a therapist is aware that their own sense of inadequacy or resentment has been evoked, this may alert them to the possibility that the patient is currently feeling shame despite their external bravado (Kealy & Ogrodniczuk, 2011).

Counter-transference experiences, left unexamined, can become an affront to the therapist's sense of professional self and often results in compassion fatigue, burnout, a sense of failure, or re-enacting familiar interpersonal patterns (e.g., rejection, abandonment, superficial relationships), which serves to reinforce the patient's dysfunctional modes of coping to defend against shame and inadequacy (e.g., self-aggrandizing, devaluation, interpersonal superficiality).

Non-judgemental awareness of countertransference and conceptualising the patient's way of coping as understandable (although not currently functional) responses to deep psychic pain associated with unmet childhood needs, helps the therapist to hold the more vulnerable parts of the patient in mind. This can enhance the ability to model a healthy adult response, even in the face of dysregulated affect, aggression, or devaluation.

Examples of developmental trauma case conceptualisations can be found in schema therapy approaches (see Young et al., 2003), psychodynamic approaches, such as object-relational models (see McWIlliams, 2011), and transference-focussed psychotherapy (see Levy, 2012). However, regardless of therapeutic orientation, case conceptualisation skills that formulate the function of NPD coping styles as having origins in developmental traumas enhance empathy for the intra-psychic suffering of the patient and give meaning to uncomfortable countertransference. These formulation skills serve to increase therapist resilience by reducing the sense of a personalised attack in session, and provide a framework for therapeutic work. This would likely improve treatment outcome, given evidence that de-stigmatization has improved treatment outcome and prognosis for other personality disorders (Ferguson, 2016; Sheehan et al., 2016).

Conclusion and Ways Forward

Despite the acceptance of NPD as a mental health disorder for over three decades (APA, 1980), there are limited rigorous long-term studies that evaluate treatment outcomes. Nonetheless, available evidence suggests that patients with NPD can improve over time with therapy (Levy et al., 2009; Behary & Dieckmann, 2013). Empirical research, supportive supervision, and the straightforward dissemination of treatment models may in time reduce stigma, in the same way Linehan's DBT model has helped reduce stigma associated with BPD.

The de-stigmatization of mental health disorders is important discourse for clinical psychologists and the widespread use of highly stigmatizing language within the profession may promote avoidance of further research and clinical work by perpetuating the perception of NPD as 'untreatable.' A sense of curiosity and awareness of developmental trauma may help to enhance empathy for patients with NPD, whilst strong supervision and training opportunities may buffer the inevitable interpersonal and countertransferential challenges of working with this population.

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