Rampant Egotism and Self-Importance:

A Psychological Report of Narcissistic Personality Disorder

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Introduction

In recent decades, increasing attention has focused on the diagnosis and the clinical manifestation of narcissistic personality disorder (NPD). DSM-IV characterized NPS as "a pervasive pattern of grandiosity, need for admiration, and lack of empathy" (APA, 2013). The DSM-V classified NPD as a cluster B personality disorder. According to the nine criteria delineating NPD, an individual must exhibit at least five of the following to be diagnosed with NPD: a grandiose sense of self-importance and preoccupied with grandiose fantasies, a belief in being special and unique, a need for admiring attention, a sense of entitlement (unreasonable expectation of special exceptions), exploitation, lack of empathy, the envy of others or belief that others envy them, with arrogance and haughtiness (APA, 2013). The estimates of the prevalence of NPD range from 0% to 6.2% in community samples; of those diagnosed with NPD, 50% to 75% are male (APA, 2013).

History

"Narcissus caught sight of his own reflection in the water. He conceived so lively a passion for this phantom, nothing could tear him away from it, and he died there…"

"Know Thyself" (inscription, Temple of Apollo), (Post, 1993)

The concept of narcissism has its roots in Greek mythology. However, the recognition of NPD and its formal study began in the 20th century. Havelock Ellis first invoked this myth to illustrate the psychological state in a clinical case of male autoeroticism (Akhtar & Thomson, 1982). Sigmund Freud then published the paper "On Narcissism" in 1914, argued that "narcissism is the libidinal complement to the egoism of the instinct of self-preservation" (Freud, 1914), namely,

the desire and energy that drives one's instinct to survive. Following these early papers, the clinical theories of narcissism are developed by Heinz Kohut and Otto Kernberg, in which both psychoanalysts posit that the defect in the development of the healthy self in early childhood is the root of adult narcissism (Kernberg, 2001). According to Kohut, narcissism is, in effect, the "developmental arrest–a halt in the child's development at a necessary stage" (Rhodewalt, 2023); he argued that pathologic narcissism occurs only with early self-object failures; in which the patients seek for "gratification of missing childhood self object needs in their adult lives" (McLean, 2007). In contrast, Kernberg's theory views narcissism as a defense mechanism resulting from the coldness and lack of empathy from one's parents; he claims that children "attempt to take refuge in some aspect of the self that evokes admiration in others," which resulted in the inflated sense of self with the unsatisfactory social relationships in the childhood (Rhodewalt, 2023).

Etiology

Early clinicians emphasized the socializing experience as the cause of NPD. Again, Kernberg states that parental coldness and over-evaluation in childhood were the key factors in predicting narcissism (Kernberg, 1989). Another early theory, according to Kohut, proposes that children come to hold grandiose self-views and a sense of entitlement through parental learning or mimicking (Kohut, 1977).

Although clinicians are prohibited from diagnosing NPD before adulthood, clinical and personality psychologists agree that narcissism typically arises well before adulthood, initially manifesting at 8 (Thomas et al., 2009). From about age 8, children begin to form self-esteem due to the increasing development in self-reflection and abstract reasoning; they would also become

"increasingly motivated to maintain favorable self-views and to avoid unfavorable self-views," demonstrated by their self-consciousness[1] and increasing use of impression management strategies[2] (Thomas et al., 2009). Supported by experimental work, researchers found that narcissism is also associated with increased loss of self-esteem following negative peer evaluation and increased negative emotion following failure (Thomas et al., 2009).

Contemporary researchers argue that narcissism is caused by the biologically based temperamental traits and motivational system, in which the overt narcissists[3] may demonstrate a high level of approach temperament while the covert narcissists[4] may demonstrate both the approach and avoidant temperament (Thomas et al., 2009). To date, only a few behavioral genetic researches have been done to examine the cause of NPD. Measured by the Narcissistic Personality Inventory (Raskin & Terry, 1988), the most widely used measure of narcissism, one study investigated 139 pairs of twins (152 MZ, 152 DZ) from the USA and Canada and found that the causes of narcissism are attributed to the genetic factors by 59% and non-shared environmental factors by 41% (Vernon et al., 2008). Another study examined a sample of 483 volunteer twin pairs (236 MZ and 247 DZ) using the Dimensional Assessment of Personality Problems scale and stated that NPD has a 45%-80% heritability (Jang et al., 1996). These statistics supported Dr. Allan N. Schore's claims that the inherited variation in hypersensitivity, strong, aggressive drive, low anxiety, and frustration tolerance are essential to the development of NPD (Schore, 1994).

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[1] Concerning how one had been viewed by others (Nishina & Juvonen, 2005).
[2] Influencing the opinions that others hold of them, for example, by acting cool (Thomas et al., 2009).
[3] People with a high level of self-esteem and extraversion (Shane-Simpson et al., 2020).
[4] People with a lower sense of self-esteem, resulting in defensiveness, feelings of insecurity, and self-consciousness (Shane-Simpson et al., 2020).

Treatment

Patients with NPD would seek treatment for multiple reasons and in different stages of life, including dissatisfaction with life, mental disorders, serious suicidal preoccupation, and personal failures. It is essential for therapists to identify patients' understanding of their problems and motivations; thus, a flexible approach to the treatments, depending on individuals' self-awareness of their problem, is especially recommended (Ronningstam & Weinberg, 2013).

Within the cognitive realm, the schema-focused therapy[5] and metacognitive interpersonal therapy[6] are originally used to treat borderline personality disorder patients, and they are now developed specially for NPD (Ronningstam & Weinberg, 2013). These treatments are especially beneficial for the patients who are motivated to learn skills for improving their self-control and for the reduction of overconfidence (Weinberg & Ronningstam, 2020). Moreover, mentalization-based treatment demonstrates great strength in treating the "high achieving professional people in crisis as it focuses on self-regulation and awareness of mental states in others" (Ronningstam & Weinberg, 2013). Similarly, cognitive behavioral therapy helps the patient to understand their behaviors and to make changes regarding their distorted behaviors; it efficiently enhance the functional outcomes among the NPD patients (Matusiewicz et al., 2010). Despite the advantages of these cognitive therapies, the characteristics of the NPD patients such as refusal to accept logical explanations and intolerance of differences of perspectives would make the therapy process less efficient (Weinberg & Ronningstam, 2020).

In general, talk therapy, also called psychotherapy, is specified for NPD, but no single treatment has been proven more efficient or reliable than others (Litin, 2009). Throughout the variety of examples of talk therapy, Psychoanalytic and psychodynamic therapy are the most

[5] Emphasizing on changing maladaptive schemas, which are rigid patterns of thinking, feeling, and behaving (Ronningstam & Weinberg, 2013).
[6] Metacognitive training brings distorted cognitive biases to the awareness of patients (Moritz et al., 2019).

prevalent (Ronningstam & Weinberg, 2013); the patients would explore their childhood experience, assessing the unconscious assumption about themselves and others that foster narcissistic attitudes (Narcissistic Personality, n.d.). Moreover, family and group therapy are also proven beneficial (Ronningstam & Weinberg, 2013). By involving the loved one in the recovery process, NPD patients could "understand the true ramifications of their self-centered behavior" (Narcissistic Personality, n.d.). However, as NPD patients are typically hypersensitive toward direct criticism, over-attending to the patient's grandiosity or talking with a passive tone should be avoided to minimize the side effect brought to the patients (Ronningstam & Weinberg, 2013). In the field of talk therapy, the challenges the interpersonal treatment would face thus include the fear of dependence or envy toward the therapist, while the self-esteem treatments would also result in perfectionism, self-hatred, or externalization of responsibility (Weinberg & Ronningstam, 2020). Still, talk therapies are widely used to treat NPD as it illustrates the effective improvement in self-esteem and pursuing long-term goals (Narcissistic Personality, n.d.).

No specific pharmacotherapy has proven effective for NPD, but it can be beneficial for treating comorbid mental disorders, such as bipolar disorder and depression, with excessive aggressiveness (Ronningstam & Weinberg, 2013). Still, for these comorbidity cases, medications are usually only moderately effective, and NPD usually takes priority of the treatments over the comorbid disorder, as the patient would lose the motivation for further treatments as their comorbid disorder "improves due to resolution of the precipitating conditions" (Ronningstam & Weinberg, 2013).

Current Study

The present researchers aim to seek improvements in the psychotherapy process. As perfectionism, aggressiveness, and shame are the common traits of NPD patients, shame could be the mediating factor in reducing aggression in NPD patients with perfectionistic traits (Fjermestad-Noll et al., 2020). Although religion is believed to be an efficient tool to reduce one's shame, a study aiming to examine the influence of religiousness on the prevalence of NPD with a sample of 618 Muslim students still finds a high level of NPD symptoms from the participants (Buzdar et al., 2019). Still, his study concludes that religious orientation directly explains the prevalence of NPD symptoms; the intrinsic personal religious orientation[7] is positively correlated with the empathy of the participants, thus lowering the NPD symptoms as the lack of empathy is the crucial indicator of NPD (Buzdar et al., 2019; APA, 2013).

Furthermore, recent studies demonstrate the benefits of integrating clinical studies and neuroscience to improve our understanding of NPD, indicated by the interactional pattern between fear and decision making (Ronningstam & Baskin-Sommers, 2022). As the dysregulation of fears and the accompanying secondary feelings such as shame and self-hatred would substantially influence the narcissistically based decision-making, treatments involving self-reflection and emotional awareness would potentially alter NPD patients' decision-making (Ronningstam & Baskin-Sommers, 2022). Accordingly, treatment focusing on "understanding and integrating vulnerability and feelings of fear in self-functioning and self-directedness" would be the most effective solution for these patients. Subsequently, this contemporary finding of addressing the role of fear and pattern of decision making may potentially diminish the limitations of the initial therapies, namely, the risks of ruptures and premature termination in the

[7] People who "sincerely believes in their religion and all its teachings and attempts to live their life as their religion teaches that they should" (Whitley & Kite, 2010).

therapy process due to patients' hypersensitivity and poor recognition of their inner state (Ronningstam & Baskin-Sommers, 2022; Weinberg & Ronningstam, 2020).

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