MBT and Narcissism

Sebastian Euler, M.D.

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«… an important aspect of technique with … narcissistic patients is to develop a shared sense of reality … through the constant demonstration … to think about the patient’s experience, thereby nurturing an experience of a secondary level of mental representation» (1998)

Anthony Bateman
1. NPD and Pathological Narcissism
2. Narcissism, Attachment, and Mentalizing
3. Narcissism and MBT
NPD
DSM-IV/DSM-5 Section II
• Grandiosity
• Fantasies of power, success, etc.
• Self-perception of being unique and superior
• Needing admiration
• Sense of entitlement
• Exploitative
  • Unwilling to empathize with the feelings, wishes, and needs of other people
• Intensely envious
• Pompous and arrogant

DSM III-R 1980: "Inability to recognize and experience how others feel"

“Lack of empathy” (ICD-10)

NPD
DSM-5 Section III: AMPD – criterion A

Self
  Identity: Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal; emotional regulation mirrors fluctuations in self-esteem
  Self-direction: Based on gaining approval from others; personal standards unreasonably high or too low; often unaware of own motivations

Interpersonal
  Empathy: Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- and underestimate of own effects on others
  Intimacy: Relationships superficial and exist to serve self-esteem regulation; little interest in other’s experiences and predominance of a need for personal gain
Pathological Narcissism
Hierarchical Model Pincus & Lukowitsky 2010, Cain et al. 2008

- e.g., entitled self-image, exploitative, behaviors, idealized fantasies
- e.g., negative self-image, self-critical, interpersonal hypersensitivity

Grandiose and Vulnerable Narcissism
Clinical Implications

Mental states fluctuate with respect to grandiosity and vulnerability (Gore and Widiger 2016, Ronningstam 2009, Bateman 1998)
- Dependent on self-esteem and control (Baskin-Sommers et al. 2014)
  - VN more similar to BPD (Gunderson 2001, Miller et al. 2010, 2011)
  - VN in BPD associated with depression and rejection sensitivity (Euler et al. 2018)
- Impact on treatment utilization, and countertransference reactions (Ellison et al. 2013)
  - VN in BPD is associated with a beneficial therapeutic alliance (Busmann et al…. Euler, under review)
2. Narcissism, Attachment, and Mentalizing

Attachment and Narcissism

- Chronic lack of support from or mismatch with attachment figures
  
  Hypo-activation of attachment system $\rightarrow$ avoidant-dismissive attachment style
  
  - Self-reliance/denial of need of others («counter-dependency»)
  - Minimizing attention to one’s own vulnerabilities and distress
  - No mirroring of vulnerable self-states by others (e.g., caregivers)

  e.g. Diamond et al. 2014

- Attachment in vulnerable narcissism might be both dismissive-avoidant and fearful-avoidant
  
  - negative self-image and rejection sensitivity

Mentalizing and Narcissism

Choi Kain & Gunderson 2008

Mentalizing and Narcissism

Affective (emotional) and cognitive empathy

- Deficits in emotional but not cognitive empathy (Ritter et al. 2012)
- Multifaceted Empathy Test (MET, Dziobek et al., 2008) and MASC in 47 NPD patients compared to BPD and HC
- Reduced gray matter in the left anterior insula in NPD, associated with lower SR empathy (Schulze et al. 2013)
- Deactivation in right anterior insula during empathy associated with narcissism in healthy subjects (Fan et al. 2011)
Mentalizing and Narcissism
Metacognition, Emotion Recognition, and Alexithymia

- Impairments in metacognition in 42 NPD compared to HC, similar to other PD in MAI (Billotta et al. 2018)
- Deficits in emotion recognition in NPD compared to HC and Cluster C (Marissen et al. 2012)
- Impairment of emotion recognition and alexithymia in HPD, NPD and BPD (Ritzl et al. 2018)
- Severity of psychopathology not type of PD predicts impairments

Discrepancy between self-assessment of capacity to understand mental states and effective ability (Ames 2004, Baskin-Sommers et al. 2014, Billotta et al. 2018)

Mentalizing Profile of NPD
Simonsen & Euler 2019
Narcissism and Mentalizing
Exploratory empirical findings

N= 73 BPD

Reflective Functioning Questionnaire
(RFQ, Fonagy et al. 2016)
Pathological Narcissism Inventory
(PNI, Pincus et al. 2009)

Hypothesis: Narcissistic grandiosity is associated with hypermentalizing (RFQc), whereas narcissistic vulnerability is associated with hypomentalizing (RFQu) in BPD

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<thead>
<tr>
<th>BPD n=73</th>
<th>Means (SD)</th>
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<tr>
<td>PNI Grandiosity</td>
<td>3.74 (0.72)</td>
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<td>PNI Vulnerability</td>
<td>4.10 (0.84)</td>
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<td>PNI Total</td>
<td>3.92 (0.67)</td>
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<tr>
<td>RFQ Certainty</td>
<td>13.23 (10.87)</td>
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<tr>
<td>RFQ Uncertainty</td>
<td>29.63 (15.79)</td>
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Correlation Matrix
(note: * = p<.05, ** = p<.01)

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<tr>
<th>BPD n=73</th>
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<td>PNI Grandiosity</td>
<td>.30 **</td>
<td>-.15</td>
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<td>PNI Vulnerability</td>
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<td>.28 **</td>
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<td>PNI Total Score</td>
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### Linear Regression Analysis

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### 3. Narcissism and MBT
Narcissism and MBT
Non-mentalizing Modes

Psychic equivalence
"Thoughts and feelings become too real"
- Lack of critical distance from own narrative
- Idealization or devaluation of clinician
  - e.g. denial of differences between minds
- Feelings of insufficiency, shame, fear, or insecurity can become "too real"
- Masochistic suffering in narcissistic crisis

Pretend mode
"Thoughts and feelings become disconnected"
- Self-centered, nonmentalistic "story-telling" (speaking "at" not "to" the clinician)
  - e.g. pseudomentalizing

« …patients with NPD can talk about issues and interact in ways that are engaging or even interpersonally sophisticated on one level, but ultimately more or less disconnected on another level, i.e., detached both from their own feeling and the feelings that they can perceive and/or evoke in others» (Ronningstam 2016, p.35)

Clinical Implications
Attachment: „patients keep the therapist at arms length“ (Bowlby 1988, p. 143)
Patients avoid interpersonal relatedness, including feelings of dependency and need (Lorenzini and Fonagy 2013)
- Therapeutic Alliance
  - Distant, disdainful, and discrediting behavior towards clinician
  - Therapists empathy is not acknowledged
    - Cave: overwhelming "therapeutic" sympathy
  - “Allergic reaction” to others’ thoughts or opinions (Britton 2004, p. 60)
  - NPD associated with aversive countertransference, and less positive therapist response (Colli et al. 2014, Tanzilli, et al. 2015)
    - e.g. rejection of patients’ boundary and corroborative needs (Bennett 2006)
- Shutting down conversations about attachment figures (e.g., AAI) (Diamond et al. 2014)
- In grandiose state patients are not willing to mentalize, in vulnerable state being exposed to others and own feelings is overwhelming (Baskin-Sommers et al. 2014)
Clinical Implications
Squaring the circle

• Titrate attachment relationship very carefully
  - Finely tuned responsiveness (optimal contingency)
    - Priority of self-esteem and control
  - Tolerate own feelings of insufficiency and devaluation
  - Awareness of iatrogenic contribution to insecure attachment and impairment in mentalizing
  - Take primary responsibility for ruptures

• Keep own mentalizing capacity and not knowing stance in mind
  • No conclusion from expressed emotions to felt feelings
  • No attribution of intentions

Clinical Implications
Squaring the circle

• Use contrary moves, but tentatively
  - Only gradually move from cognition to affective mentalizing
  - Engage and connect with self-centredness before mentalizing others
    - Validation and acknowledging of self-attention in “stories”

• Challenge mildly
  - e.g. with a slightly questioning but nonironic tone
MBT and narcissism
Pitfalls I: Mentalizing the other («I am not my wife»)

MBT-I Group with 4 patients in Inpatient PD Treatment
- Mr. R. 28y NPD
- Mrs. S. 38y BPD, AN
- Mrs. M. 19y, BPD
- Mr. W. 23y, AvPD

- Mr. R. (2nd MBT-I session) is sitting in a comfortable chair, eyes half-shut, legs straight forward (everyone entering has to walk around).
- He starts complaining about the term «mentalizing» which could much easier be called «emphathizing» (In the session before, he was confused by the concept and eventually disclosed that he was overcharged feeling dumb like when he was in school).
- Therapist empathically validates his view and then tries to include the other patients.

- Mr. W. starts to tell a «story» about a conflict with his girlfriend in a very factual and long-winded manner.
- Mr. R. and Mrs. M. exchange glances and roll their eyes.
- Mrs. S. is carefully «observing» the scene.

MBT and narcissism
Pitfalls II: Balancing Attachment Arousal
Mr. R. suddenly laughs out loud and then immediately excuses himself.

Upon the request of the therapist he says, he thought about something else which made him laugh, while turning himself around in the chair putting his feet on the armrest.

Asked about the intentions for the changed seat position, he replies, it was just more comfortable and the therapist should ignore him - but he might also get back in the normal position if the therapist feels disturbed (what he then does).

The therapist now declares he would be very curious about his current state of mind and if he likely what made him changing the position asks if he might leave the group.

Mr. S. expresses her view that Mr. R. takes too much space in the group and that the therapist should just have done as suggested: Ignore him.

After he has left, the therapist asks the group what went wrong.

Narcissism and MBT
Research Outlook: Narcissism and mentalizing in MBT

SCID-II
PNI and NPI
RFQ and MentS (Dimitrijević et al. 2018)
BSL-23
STAI
FFMQ (Mindfulness skills)
AAQUOL (Quality of life)
«The patient is not hard to reach but we find it hard to reach him/her»
Fonagy, Luyten & Allison 2015

Pieter van Eenoge, Zeit Magazin 8.8.2019