The individual diagnosed with Narcissistic Personality Disorder presents with grandiosity, extreme self-involvement, and lack of interest in and empathy for others. This paper reviews current theories concerning the development and treatment of Narcissistic Personality Disorder, and introduces the use of Ego State Therapy for its treatment. The ego state model of treatment will be described and demonstrated with case material. Initially ego states that reveal the grandiosity will be accessed. As therapy progresses, ego states that hold the underlying feelings of emptiness, rage, and depression are able to emerge. With further treatment, transformation and maturation of the ego states occur, reflecting the changes in internal structure and dynamics as well as improvement in external interpersonal relationships. Issues concerning Ego State Therapy as utilized with personality disorders will be discussed and contrasted with more traditional methods of treatment.

**Keywords:** Character disorder, ego-strengthening, Ego State Therapy, false self, hypnosis, hypnotic age progression, narcissism, personality
“personality disorder”. Though some degree of confusion persists, according to Livesley (2001), character is usually used to refer to “... aspects of personality that are assumed to be the product of learning and interaction with the environment” (p.8). This definition is in contrast to the term “temperament” which refers more to genetically determined traits, although as we know this distinction is never clear-cut.

For the purposes of this paper, the words character and personality will be used interchangeably. Personality disorders have become more recognized and focused upon during the past two decades, coinciding with the publication of DSM-III in 1980 (Livesley, 2001). A personality disorder, as defined by DSM-IV TR is,

An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture. This pattern is manifested in two (or more) of the following areas: (1) cognition (i.e. ways of perceiving and interpreting self, other people, and events), (2) affectivity (i.e. the range, intensity, lability and appropriateness of emotional response), (3) interpersonal functioning, and (4) impulse control. The enduring pattern is inflexible and persuasive across a broad range of personal and social situations (American Psychiatric Association, 2000, p. 287).

Included in the category of personality disorders are paranoid, schizoid, schizotypal, antisocial, borderline, histrionic, narcissistic, avoidant, dependent, and obsessive-compulsive personality disorder.

**Narcissistic Personality Disorder**

This paper will focus on the category of Narcissistic Personality Disorder which is defined by DSM IV TR as,

A persuasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following. (1) Has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements), (2) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love, (3) believes that he or she is “special” and unique and can only be understood by, or should associate with other special or high status people (or situations), (4) requires excessive admiration, (5) has a sense of entitlement, i.e. unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations, (6) is interpersonally exploitive, i.e. takes advantage of others to achieve his or her own ends, (7) lacks empathy; is unwilling to recognize or identify with the feelings and needs of others, (8) is often envious of others or believes that others are envious of him or her, and (9) shows arrogant, haughty behaviors or attitudes” (American Psychiatric Association, 2000, p. 294).
The Narcissistic Personality Disorder has been explored extensively from the vantage point of differing theoretical systems including traditional psychoanalytic theory, ego psychology, object relations, self psychology, and social learning theory. Writers such as Kohut (1971, 1984), Kernberg (1975, 1984), and Masterson (1981, 1985, 1988) produced the most extensive analyses of this disorder during the 1970’s and 80’s. More recently clinicians such as Chessick (1993), Johnson (1987, 1994), and Giovacchini (2000) have reviewed, synthesized, added to, and integrated concepts from these theories. Johnson (1987, 1994) in particular, has comprehensively presented a picture of the narcissistic personality from a developmental perspective, and his conceptualizations will be utilized extensively in this paper.

To complicate the diagnostic issues, a number of writers (Johnson, 1987, 1994; Ronningstam, 2000) have identified a spectrum of narcissism and described what is called a “narcissistic style” that could co-exist with other diagnostic categories. For example Johnson (1987) speaks about a continuum with the lower end in the borderline extreme of the narcissistic continuum. These individuals have less observing egos, weaker ego boundaries, and more fragile and profoundly arrested senses of self. At the other end of the continuum, those with only a narcissistic style have stronger observing egos, stronger boundaries and defenses, more ego strength, and less damaged senses of self. In the latter group there may also be more depression, pain, illness, or other symptoms that appear more characteristically neurotic. The individual with a neurotic style is less likely to act out, less prone to strong transference reactions, and more open to the interpretation of these reactions. However, according to Johnson (1987), if the treatment is successful in accessing the archaic demands and affects of the real self, there may be extreme reactions to these intense emotions. An individual with a narcissistic style is likely to become depressed in defense of these feelings and may act out self-destructively. This kind of person is similar to what Masterson (1988) has referred to as the “closet narcissist” who in the course of treatment must experience and work through an “abandonment depression”. Johnson (1987) believes that people at both ends of the continuum come for therapy when there is a severe breakdown in functioning. While one condition appears more serious than the other, underneath the essential similarity is the betrayal of the real self as a child and continued betrayal of the real self in adulthood.

Psychodynamics of Narcissism

According to Masterson (1981, 1988) and Johnson (1987, 1994) the narcissistic character is developed during Mahler’s (1972) rapprochement subphase of separation-individuation occurring approximately at the age of 15 to 24 months. During the previous practicing subphase the child experienced great narcissistic investment in his own functions and body, appearing oblivious to the mother’s presence. At the end of this period the rapprochement with reality involves experiencing separation anxiety when the mother is not present, and also features the need to reconnect with mother. When the child experiences his/her limitations, he/she loses a sense of grandiosity and omnipotence. Fixation of the narcissistic personality takes place before the end of this period resulting in the fantasy that the world revolves around him/her.

During each developmental phase, the child is frustrated by failure in certain need gratifications. Through the maternal response to frustration, the child begins to
develop ego structure and the experience of the self, as he/she internalizes the soothing functions of the external caregiver. According to Johnson (1987), when the need to integrate independence and dependence or grandiosity and vulnerability is frustrated or inappropriately dealt with, the result may be a refusal to accept rapprochement with reality. Then the infant regresses to illusions of grandiosity and symbiotic unity. In normal development the child confronting separateness and vulnerability experiences his/her own limitations and powerlessness. The “good-enough mother” provides the necessary understanding, sympathy, mirroring, and respect. “Narcissistic character derives primarily from failure to accommodate around grandiosity and limitation” (Johnson, 1987, p. 29).

The “narcissistic injury” is the deep wound to the experience of the real self that is caused by the failure of the caretaker to respond appropriately. According to Johnson’s developmental theories, those showing the most serious narcissistic adaptation had clearly deficient parenting in the period requiring nurturing and holding. When the environment provides too much (idealization), or too little (deficient mirroring or humiliation), the developing child cannot fully realize himself or herself. Accordingly, narcissistic pathology is the result of the child becoming who he or she needed to be rather than the person he or she really is. The developmental arrest occurs at the point when the child needs supportive mirroring to grow to become oneself. When appropriate and sufficient mirroring are not available, the result is rejection of the real self. The false self is developed and maintained as an attempt at compensation for what is missing. What has been rejected in oneself (limitations, imperfection, dependency needs) also becomes rejected in others, leading to their devaluation.

**Traditional Treatment of Narcissism**

Successful treatment of the narcissistic personality according to Johnson (1994) involves reclaiming healthy narcissism and acceptance of being vulnerable, limited, needy, dependent, and weak at times. Working through the inevitable abandonment depression and integration of the grandiose and vulnerable selves is required. In the process, the person shifts from the use of others to perpetuate the false self to use of others to discover the real self. In therapy he/she may reveal feelings of never being or having enough and may admit that he/she only fools others. These patients can become very blaming of those perceived as causing their pain. The therapist needs to show respect for the intensity of their pain. Transformation is possible when there is enough of a therapeutic relationship and when the ego strength to experience the depth of feelings of worthlessness and desperation has been acquired. The relationship is healing in that the narcissistic individual can feel real human feelings that are unaffected by parental acceptance or rejection.

The nature of transferences varies across the spectrum of narcissistic styles. At the lower end is the *merger transference* in which the therapist is expected to be available always and to gratify all needs. At the higher end of the spectrum, the transference may be more like Kohut’s (1971) *twinship transference*, one in which the narcissistic patient thinks he and the therapist are just alike. At the highest end of the spectrum, the patient expects the therapist to mirror the false self. It is the therapist’s task to access whatever real self is there and further that development. Appropriate empathy is crucial as the individual begins to feel extremely vulnerable and to experience
overwhelming affect. The loss of the false self amounts to the loss of the ability to manipulate the environment and to be in control; so, fears of being manipulated, humiliated, and used can emerge, i.e. the fear of being injured again or as Masterson (1988) terms it, the “abandonment depression”.

Johnson (1994) defines the therapeutic objectives as the discovery and enhancement of natural self-expression. The patient must learn and feel how he/she has sacrificed him/herself, then mourn his/her losses, rediscover his/her own deeply buried needs, and attempt to meet them. Johnson (1994) defines character transformation as maturation that involves the development of creativity, the acceptance of transience, and development of the capacities for empathy, a sense of humor, and wisdom.

The therapist needs to provide empathy, regard, and a safe place for the patient to experience his or her pain. Interpretation or reframing can emphasize pain as a signal in such a way as to enhance internal exploration. Interpretation can relate current injuries, anger, and disappointments to earlier failures of the environment to meet the person’s legitimate needs, while also providing support for the person’s innate capabilities combined with realistic assessment of abilities, resources, weaknesses, and limitations. Trust is especially important because the narcissistic person needs most to be understood. It is important to access his/her real need for others and to provide training in how to become a more social being within a support system that will help the person find himself or herself. The patient ultimately makes the decision to grow up, to accept his or her humanity, and finally let in the love and acceptance that others can provide (Johnson, 1994).

**Hypnotic Treatment of Narcissism**

Johnson (1994) mentions ways in which he believes that hypnosis can be helpful in the treatment of Narcissistic Personality Disorder and narcissistic styles. He believes that hypnosis can be helpful in the working-through process by facilitating the discovery of the origins of symptoms. He also suggests that hypnosis may be helpful in speeding up the process of discovering and developing the real self. However, Johnson does not give examples of how he has used hypnosis in treatment.

Baker (1981) has developed hypnotic techniques for use in the treatment of patients with narcissistic and borderline personality disorders. He utilized concepts from object relations and self psychology based in the work of Mahler (1968) that are helpful in working with seriously disturbed patients. Baker’s hypnotic exercises allow patients to have corrective experiences in the present within the framework of the psychotherapeutic session. His fifth, sixth, and seventh exercises in particular, address stages of therapy with a patient with narcissistic character disorder in which the goal is object constancy. The exercises enhance introjection of the therapist as a “good object” and the self as “good me”. Then imagery can be created for the purpose of getting rid of the “bad object”. The seventh step addresses integrating positive and negative experiences. Imagery can also address how some things stay the same across changes, such as the color of one’s skin and eyes and going from one place to another in the same clothes. It also emphasizes imagery for mending what has been broken, with visualizations of fixing, blending, putting together, etc. Baker also promotes imagery for management of affect and management of splitting as a defense. He recommends using
imagery and fantasy rather than relaxation for the narcissistic patient. This helps to create transitional objects that are experienced through symbols of safety, security, and comfort. Baker also emphasizes the importance of empathy as well as the need for the therapist to help the patient build an observing ego. Murray-Jobsis (1990a, 1990b, 1990c) also has developed imagery that involves moving through developmental stages—from discovering the physical body and boundaries, to dealing with the external world, as well as accepting an imperfect world, and enjoying separateness.

These authors have focused on hypnotic imagery that helps to negotiate incomplete developmental tasks. Their techniques are especially valuable in working with patients who are diagnosed with psychosis, borderline personality disorder, and with seriously disturbed narcissistic personality disorders. However, other hypnotic methods may also be useful in working with patients with milder narcissistic disorders or narcissistic styles. The present paper presents the therapy process with a narcissistic patient who is fairly high functioning. This patient already had developed a good observing ego and spoke of himself in the language of parts of his personality. In view of his “language of parts” a decision was made to utilize Ego State Therapy (Watkins & Watkins, 1987), and some interesting results ensued.

Case Study

George, age 48, came to see me because he was very interested in clinical hypnosis. He had been reading books about it, and thought it would be helpful for him. His previous treatment had involved a short course of cognitive-behavioral therapy for dealing with Post-Traumatic Stress Disorder. He was currently attending Adults who were Sexually Abused as Children Anonymous (ASCA) meetings, and had found them to be very disturbing to him. He believed that he had been sexually abused by his mother for much of his young life, and had memories of numerous traumatic events. George also reported that he had observed his mother trying to kill his younger sister by smothering her with a pillow, and he felt that he had always lived in fear of losing his own life. He mentioned a number of unusual phobias and ways in which he knew his emotional reactions were exaggerated. For example, when anything slid, fell, or moved unexpectedly, he would feel panic. Whenever he leaned over in a sitting position, he would feel nauseated and not know why. He also felt that he had never really achieved his true potential or been successful in the way he would have liked.

From his initial presentation, it seemed as if a diagnosis of Post-Traumatic Stress Disorder (PTSD) would be appropriate. However, in our early sessions he also talked a great deal about how intelligent and creative he was and how much professional reading he was doing. He also spoke about all of the well-known people in the San Francisco Bay area whom he knew and with whom he interacted. George said that he was in an MBA program and that he also intended to go to law school. He planned to write several books and to pursue oil painting as well. However, the reality of his present life was that he was a building contractor who had lost his license and was unemployed. He had been evicted from his rental unit and was moving back into the childhood home that he had inherited when his mother died. The house had been empty for many years, and he was planning to fix it up. He also spoke very harshly and critically of his ex-wife, his present girlfriend, his neighbors, and his lawyer. My diagnostic impression was that in addition to the Axis A diagnosis of Post-Traumatic Stress
Disorder (PTSD), an Axis B disorder, Narcissistic Personality Disorder, was also present. In our beginning sessions the focus was on developing our relationship and defining the therapeutic goals. Along with his frequent boasting, George could occasionally also talk about his pain. I felt that his observing ego was strong enough to do Ego State Therapy, and we began with trance work for accessing and strengthening inner resources. In trance he reported a Tuscan palace filled with people including Achilles, Marcus Aurelius, Genghis Kahn, General Patton, Leonardo de Vinci, and Alexander the Great. Coming out of trance, he was enthused to find such an impressive collection of powerful and talented individuals within himself. However, by the next session he seemed to have forgotten about the experience and didn’t mention these individuals again. During subsequent sessions I utilized the affect bridge technique (Watkins, 1971) to explore the origins of the phobic reactions he had reported, along with further exploration of early trauma that he could recall. We accessed a strong helper ego state who was an introject of his grandfather, the only person he felt “had been nice” to him during his childhood. There was a young child ego state that had been terribly traumatized. Two other ego states present were parental introjects. The one he named “Naïve” held his mother’s perceived traits, and he described her as pathetic, lazy, feeling worthless, and just waiting for something to happen. The other, whom he termed “Criminal,” he saw as petty and scheming. George’s father had been depressed and alcoholic. After his business had failed and he had served time in prison for embezzlement, he died in a skid row hotel. George himself had previously used drugs, primarily speed, and had at one time operated a methamphetamine laboratory. He had been caught and spent some time in jail and on probation.

As a result of individual therapy with the ego states, Criminal and Naïve, Criminal became more motivated to go straight, maintain sobriety, and use his street smarts in more productive ways. The ego state, Naïve, began to learn that she had made bad decisions in the past and had associated with others who were unscrupulous. Naïve gained insight about self-sabotage and began to understand that she had not given George permission to achieve and go beyond what his parents had been able to accomplish. In his external life George began to pick up some loose ends and finish projects he had started. He initiated action to regain his contractor’s license and enrolled again in school to continue taking courses toward his MBA.

Then a transference issue surfaced. It had to do with George’s fear that if he didn’t “get it all together real soon,” I would kick him out of therapy. As we worked through the transference, George became more vulnerable and began to talk about his loneliness, misery, and confusion about what he felt he was really capable of doing. He spoke at length of how he had always lived as if, at any moment, he could die. His grandiosity greatly decreased. He had been in the habit of shaking my hand at the end of the session. Coinciding with this period in therapy he said at the end of a session, “I’m not going to shake your hand anymore, because that made me feel like we were colleagues, and I know we are not.”

Combined with ego-strengthening his vulnerable child ego state, we continued to access, explore, and reframe early traumatic experiences. Two themes were predominant. One was linked to an incident that had occurred when he was four. He had walked into his one-year-old sister’s room and observed his mother holding a pillow over her head. After that time George lived in fear that his mother would try to kill him, too. It became clear why small things such as something slipping or falling could cause
such panic for George. He felt he had learned to handle obvious life or death situations, but not the small unexpected, unanticipated happenings of everyday life.

Another theme that emerged involved George’s fear that whatever he managed to achieve would be taken away from him. The early sexual abuse had involved his mother exhibiting her genitalia to him and anally molesting him with her fingers in the bathroom. Additionally, both parents had also ridiculed him. Both the humiliation and the invasion of his boundaries had produced the belief that nothing about him was his alone and not to be used or manipulated by others.

A further development had to do with George’s relationship with his girlfriend of whom he had spoken very critically early in treatment. He began to refer to her more positively, saying that although he knew she wasn’t perfect, she had some qualities he could respect. He reported that they were becoming closer. He expressed pride in the fact that he was learning to hold his tongue and be kinder toward her. At the same time he expressed (with some amazement) that he was beginning to feel that he didn’t have to know everything. He mused that maybe it was okay at times to just admit to others that he didn’t know about something, but that maybe he could learn. He stated that he didn’t have to win at all times anymore, or always be right. George began to talk about the importance of values and of figuring out what he wanted his values to be. He spoke of wanting to achieve something that he could do honestly and ethically. Hypnotic age projections (Phillips & Frederick, 1993) were useful in facilitating ideas of what he could do in the future. He saw himself building a studio where he could have his computer and perhaps materials for painting and crafts. In these visualizations the emphasis was on utilizing his building skills to create a private and comfortable space for himself.

Recently, Ego State Therapy has revealed his ego states moving into a new constellation. The ego states of Naïve and Criminal are intertwined, and George has said that they represent his old self that is not his current and real self. He now experiences a part of himself, formerly the vulnerable child ego state, as what he terms his “authentic self.” We are currently working on strengthening this authentic self with ego-strengthening techniques and self-hypnosis (Frederick & McNeal, 1999). Therapy continues at this time, a year since the beginning, but it is definitely approaching the final stages of treatment.

**Discussion**

This case study illustrates the progress of treatment of an individual with Narcissistic Personality Disorder unfolding much as would be expected in traditional psychodynamic treatment. George progressed from grandiosity, entitlement, and a lack of empathy for others toward maturation and development of more realistic perceptions of self and others. However, the use of hypnotic techniques such as the affect bridge (Watkins, 1971), future projections (Phillips & Frederick, 1993), an assortment of other ego-strengthening techniques (Frederick & McNeal, 1999), and Ego State Therapy (Watkins & Watkins, 1987) have reduced the course of treatment from the usual two to three years to a little over one year.

In the early stage of treatment, reliance on the grandiose false self was illustrated by George’s short-lived discovery of an internal world populated by powerful male figures. As therapy progressed, he was able to access a helper ego state modeled on a real-life nurturing person, his actual grandfather. Initially work needed to be done with
his internalized “bad objects”, i.e. the ego states of Naïve and Criminal that were parental introjects. As his anger toward them began to dissipate, he was able to experience a wounded child ego state and work through the traumas that he had experienced. This was very much akin to working through abandonment depression. It is possible that Ego State Therapy facilitated this stage of treatment because the functions of the ego states could be so clearly differentiated and understood. Then the vulnerable child state was nurtured and strengthened, ultimately transforming into the authentic or real self.

In traditional psychotherapy the patient often displays strong resistance to letting go of the false self because of fear of being overwhelmed by the pain that is being held by the wounded real self. With the use of Ego State Therapy, the wounded real self can be contained, nurtured, strengthened, and protected from malevolent ego states so that the fear of being overwhelmed is reduced and the false self can be released more easily. This is one of the major advantages of Ego State Therapy with the narcissistic patient.

The use of age regression with the affect bridge technique (Watkins, 1971) also facilitated working through the traumatic origins of symptoms in a safe, paced, and contained manner allowing for George to deal with intense painful emotions in a context of safety. In the transference George illustrated Kohut’s concept of twinship, whereby George initially wanted to believe that he was on an equal footing with the therapist. A turning point in George’s therapy was his acknowledgment that he was not really a colleague of the therapist.

The loss of his false self was accompanied by George’s fears of being abandoned by his therapist and used and manipulated by others. However, the continued use of Ego State Therapy allowed him to develop insight into the origins of those feelings and subsequently to develop more realistic and empathic relationships with others in his life. With Ego State Therapy there is less interpretation involved than in traditional therapy. This reduces the possibility of further narcissistic injury to the patient by the therapist.

Now, in the final stages of therapy, Ego State Therapy has been helpful in the maturation and strengthening of George’s real self. Future projections and ego-strengthening techniques have facilitated this phase of therapy. George is now experiencing his real self, and he calls it his authentic self. The use of self-hypnosis can further enhance this process in helping him to build internal structure, and consolidate his new identity. We might say that the “character” named George has almost completed his search for character.

In this case study, Ego State Therapy was successfully utilized and integrated into hypnotically facilitated psychotherapy with an individual diagnosed with Narcissistic Personality Disorder. However, hypnotic methods such as the ones described here might be contraindicated in the presence of a more severe degree of pathology in a person with narcissistic symptoms. Careful evaluation of the patient’s ego strength and reality contact is important before using these methods. Hypnotic approaches such as those developed by Baker (1981) or Murray-Jobsis (1990a, 1990b, 1990c) might be more appropriate for more severely disturbed patients. It is wise not to use ego-strengthening in the early stages of therapy with patients with Narcissistic
Personality Disorder. If ego-strengthening techniques are employed too soon, they could inadvertently strengthen the false self and reinforce the patient’s grandiosity. Careful timing of the use of ego-strengthening techniques is necessary and must always be used in combination with a strong therapeutic alliance and an empathic therapeutic stance. In conclusion, it appears that Ego State Therapy can enhance and speed up the treatment of Narcissistic Personality Disorder. It is anticipated that this may prove to be true in the treatment of other personality disorders as well.

References


