The Addicted Narcissist

How Substance Addiction Contributes
to Pathological Narcissism
with Implications for Treatment

A Hermeneutic Literature Review

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments), nor material which, to a substantial extent, has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Kim Laurence

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ABSTRACT

The narcissistic client is among the most difficult to treat, yet Narcissistic Personality Disorder is the least researched in the category in which it fits (Campbell, Miller, & Pilkonis, 2007). Narcissism, in general, is becoming a Western cultural phenomenon as individualism is becoming more encouraged over community values. The increased rate of substance dependency disorders runs parallel to the increased sense of grandiosity and entitlement in the 21st century (Twenge, 2006). Substance use among the general population is increasingly becoming a public health issue and is associated with many social, psychological and physiological costs that affect both addict and the people in their lives (Ham & Hope, 2003).

This dissertation is a hermeneutic literature review, examining the relationship between pathological narcissism and addiction, and in particular, the narcissistic individual who enters into substance dependency. The research identified a number of themes in the literature, including personality as a predisposition to addiction, a connection with differential diagnoses, relevance of specific personality characteristics, substance use as self-medication, and disengagement with Alcoholics Anonymous. The research also identified significant gaps in currently available literature, including the examination of covert narcissism, and interpersonal relationships relevant to the addicted narcissist. In addition to summarising, exploring and discussing the themes of the literature, another aim was to consider the implications these findings have for the treatment of the client population.

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CHAPTER ONE: INTRODUCTION

In the ongoing quest to understand more about my personality, and my relationship with myself and others (or quite simply, who I am and why I am the way I am) I have consistently come across the significance of my relationship with my parents. What particularly stands out and what I have repeatedly confronted through my experiences as a psychology undergraduate student, a psychotherapy postgraduate student, and in personal therapy; is making sense of my experiences as a child of a narcissistic parent. From a personal standpoint, I wonder about the impact this has had on my personality development. I consider the ways in which my experiences may have impinged on my development, such as having internalised experiences of devaluation; and also the ways in which they perhaps have supported to make me stronger, more independent, and resilient. As I make more sense of my experiences and develop empathy for my narcissistic father, I begin to think beyond the realm of my own experience. I also consider who my father is (and has been), why he is the way he is, his relationship with self and others - and of course with me, as his daughter. It is this journey, a quest for 'self and other' understanding, which has inspired my interest in the topic of narcissism.

As part of my psychotherapy studies, I attended a two-year placement as a student counsellor in a therapeutic community for addictions, where I continue to work as a locum practitioner. My initial role was in assessment and psychotherapy practice with individual clients, which has since grown into AOD (alcohol and drug) locum case manager, tending to a number of responsibilities such as assessment, education, co-facilitation, treatment planning; and individual, group, and family therapy. It was through the learning and experience I gained while working with this particular client group, that I came to realise not only was my father narcissistic, but he was also alcoholic.

The longer I worked at the clinic, the more I was exposed to the personalities of addicted clients and to discussions about these individuals with my colleagues, and the more experience I had being in relationship with them. I was consistently confronted with the subject of narcissism, whether formally in clinical meetings, supervision, and

with clients; or informally among colleagues. Themes of grandiosity and entitlement were frequently discussed in group therapy, were part of individual client work, and indeed even became part of the culture of the therapeutic community with clients themselves challenging each other for their "grandi" (grandiose) and entitled behaviour. It was through this journey that I became interested in the topic of substance addiction, and that I began to wonder why and how narcissism was so present. Together, the topics of narcissism and addiction felt particularly confronting, but I was also inspired to explore, deepen understandings, and make meaning of my experiences.

As a psychotherapy practitioner, I not only consider whether there is a relationship between narcissism and addiction - but more importantly, what this might mean in terms of treatment with narcissistic and/or addicted clients. I have taken opportunities through my studies and personal therapy to locate myself as a daughter in relation to the (often traumatic) experiences of growing up with a narcissistic alcoholic parent. However, I am also interested in locating myself as a Western female psychotherapist in the 21st century - and in this context, in relation to the narcissistic addicted client.

A Case for Research

Presently, narcissism can be described as a metaphorical description of Western culture in general, and indeed, authors have written books about such an occurrence (for example, *The Narcissistic Epidemic*; Campbell & Twenge, 2009). Societal norms contribute to the development of narcissistic disorders by encouraging a preoccupation with the lifestyles of the rich and famous rather than the average person; social approval of open displays of money or status rather than modesty and self-restraint; preference for physical appearance rather than beliefs and values; and the weakening of community values for more individualistic values (Encyclopaedia of Mental Disorders, 2016). Narcissism is an important trait to understand because narcissistic individuals have a number of difficulties maintaining healthy and strong interpersonal relationships, which are fundamental to fulfilling core human needs, such as the need to belong. Interpersonal relationships are typically impaired due to problems caused by a sense of entitlement, the need for admiration, and the relative disregard for the sensitivities of others (Campbell, 1999). Though ambition and

confidence in narcissistic individuals may lead to high achievement, performance can be easily disrupted due to their sensitivity to shame, which may then result in outrage, social withdrawal, depression, and/or substance abuse (Estrin, 2003).

The increased rate of substance dependency disorders runs parallel to an increased sense of grandiosity and entitlement in the 21st century (Twenge, 2006). Substance use among the general population is increasingly becoming a public health issue and is associated with many social, psychological and physiological costs that affect both the addict and the people in their lives (Ham & Hope, 2003). Additionally, Narcissistic Personality Disorder is the least researched in the category of disorders in which it fits, despite being highly comorbid with other disorders (Campbell, Miller, & Pilkonis, 2007) and in becoming a Western cultural phenomenon. Because of this lack of research, public understandings are very limited, and more research is needed to explore the more specific facets of narcissism, such as its relationship to addiction.

Due to the increased prevalence of substance abuse, addictions, and the associated negative implications; it is important to identify the mechanisms behind increased risk of substance use, of which I propose narcissism to be one factor. Donnellan, Robins, and Trzesniewski (2008) have suggested that rather than an increase in overall narcissism levels in today's society, specific features of narcissism (such as vanity or exploitativeness) have shifted over generations, and it is therefore critical to examine narcissism as a multi-faceted construct.

Aims of the Research

This research then, is designed to advance a more thorough examination of the relationship between narcissism and addiction – and more specifically, the presence of addiction in relation to a narcissistic personality. Exploring this relationship might prove helpful in conceptualising and further investigating if and how narcissism might be a possible precursor to addiction, whether narcissism should be addressed as one of the underpinnings of addiction, and whether substance abuse or addiction should be more rigorously addressed with narcissistic clients. I look to support the literature by researching correlations between the two subject areas, with a primary aim to deepen current understandings so that practitioners may be better able to address the needs of the relevant client populations.

Research Question

When I began investigating a reciprocal relationship between addiction and narcissism (such as how each is related to the other) there appeared to already be an abundance of literature and research on narcissism within the addiction literature, but very limited research on addiction within the literature on narcissism, and so I was interested in contributing more to this specific perspective. Also, given that my own personal experience is based a parent with a narcissistic personality with secondary alcoholism, and my stance as a psychotherapist viewing addiction as a symptom rather than a cause, it was the subject of narcissism to which I was most drawn. So with this in mind, and with the amount of available literature on addictions (more suitable for a doctorate), I instead chose to contain the topic by focusing on the side of narcissism for the purpose of a 60-point dissertation. However, it was inevitable that the reciprocal relationship would in some ways permeate the research.

My research question therefore is: *How does substance addiction contribute to pathological narcissism?*

Definition of Terms

Narcissism refers to an individual's tendency towards self-centredness, with a reliance on external approval for self-esteem (McWilliams, 2011). The is explained more fully in the next chapter including variations and subtypes of narcissism, healthy and pathological.

Narcissistic Personality refers to an individual's thoughts, feelings, beliefs and actions (personality) consistently reflected as being narcissistic in nature.

Narcissistic Personality Disorder (NPD) is a clinical term used to describe the diagnosis of a narcissistic personality in the *Diagnostic and Statistical Manual of Mental Disorders (DSM),* according to a set of specific criteria.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) is a standardised diagnostic handbook offering criteria for the classification of mental disorders.

The Psychodynamic Diagnostic Manual (PDM) is an alternative diagnostic handbook adapted from the classical psychoanalytic tradition of psychotherapy. Rather than a

set of observable criteria, the PDM focuses on the subjective internal experiences of an individual.

Substance Use Disorder (SUD) is explained more fully in the next chapter, however, I thought it important to define the term 'substance', which refers to any form of drugs or alcohol. SUDs then, refer to the clinical diagnosis of an addiction to a substance.

Dual Diagnosis refers to co-occurring mental illness alongside a substance use disorder.

Comorbidity refers to the presence of one or more additional disorders co-occurring alongside a primary disorder. In the context of this dissertation, this may include more than one mental, personality, or substance use disorders.

'False Self' (Winnicott, 1965) is a concept in psychoanalysis describing a defensive façade which an individual maintains based on the needs of others, rather than expressing a creative and spontaneous 'true' self based on one's own needs.

Grandiosity is a trait frequently linked to overtly narcissistic individuals. It refers to an unrealistic sense of superiority, a view that oneself is better than others, and others are viewed with disdain and as inferior. Grandiosity also incorporates a sense of specialness, the belief that oneself is exceptional, and can only be understood by few others.

OVERVIEW OF CHAPTERS

The following chapter, chapter 2, outlines the context for this dissertation; introducing narcissism, addiction, and the co-occurrence of both disorders. Chapter 3 describes the qualitative methodology of hermeneutics used as a basis for the research, and chapter 4, the method and process of undertaking this research. Chapter 5 provides an overview and discussion of themes that emerged in the process of reviewing the literature. Chapter 6 summarises the overall findings, the strengths and limitations of the study, implications for treatment in the field of psychotherapy and addictions, and concluding comments.

CHAPTER SUMMARY

In this chapter, I have introduced the topics of narcissism and addiction and the significance of research in these subject areas. I have also outlined my personal standpoint as a researcher, and then lens through which I observe the research and interpret the findings. I have defined my research question, and provided definitions of terms which are referred to throughout the body of work.

The next chapter is an overview of literature providing context for the research. This includes an introduction to narcissism, healthy and pathological definitions, overt and covert subtypes, Narcissistic Personality Disorder (NPD), psychoanalytic perspectives, and prevalence. It also includes an introduction to addiction; use, abuse and dependence; Substance Use Disorder (SUD), the disease model of addiction, recovery programmes, psychoanalytic perspectives, and prevalence. Finally, the next chapter provides a brief overview of the comorbidity of narcissism and addiction.

CHAPTER TWO: CONTEXT FOR THE STUDY

NARCISSISM

Looking at me,

looking at me in the mirror that's looking at me

and looking, I see me looking at me

and me looking at me, looking.

Lucky mirror.

(Anonymous)

The ancient Greeks tell us that Narcissus was a handsome, yet arrogant young man. He was insensitive to the affections of Echo, a young woman who loved and admired him. The Gods avenged Echo's distress by ensuring Narcissus would feel what it was like to experience unrequited love. Narcissus was lured to a pool where he fell in love with his own image; pining for and unable to leave the beauty of his reflection, he withered away until his death (Bulfinch, 1855).

The term *narcissism* derives from this Greek myth, and is a concept in psychoanalytic theory introduced in Freud's 'On narcissism; an introduction' (1914). As with Narcissus, the central concept revolves around self-reference and self-centredness (Stone, 1998). Bonadonna and Kourath (2014) add to this self-preoccupation, a desire for recognition and feelings of specialness, though the more malignant and well-known traits, such as exploitativeness, arrogance, envy, and preoccupation with power and success, were not considered part of Narcissus' personality.

Lukowitsky and Pincus (2010) define the concept of narcissism as an individual's capacity to maintain a relatively positive self-image through a variety of self and affect-regulatory processes, with an underlying need for validation, affirmation, and self-enhancing experiences from others. Similarly, McWillams' (2011) definition involves an individual whose personality is "organised around maintaining their self-esteem by getting affirmation from outside themselves" (p 176). Kernberg (1985) also comments

on these dependency needs (to be admired and praised), though reflects that narcissistic individuals are ultimately unable to depend on anyone else on a deeper level because of their mistrust and depreciation of others.   He further describes the narcissist as having a shallow emotional life, grandiose fantasies, experiencing little empathy, and being envious and idealising or devaluing of others. Additionally, Cooper (1984) suggests that the common feature among narcissistic individuals is an inner sense and fear of insufficiency, shame, weakness, and inferiority.

McWilliams (2011) reports on a common theme among narcissistic writing, that "in every vain, grandiose narcissist hides a self-conscious, shame faced child, and in every depressed and self-critical narcissist lurks a grandiose version of what that person should or could be" (p. 171).

Healthy Narcissism

In most cases narcissism is referred to in its pathological state and in extreme cases is defined as a clinical/personality disorder. However, several psychoanalytical theorists distinguish between healthy and pathological narcissism (Freud, 1957; Kohut, 1971; Kernberg, 1975). One common theory is that narcissism is a part of normal development in infancy which serves to develop and reinforce a child's sense of self, separate to, but dependent on their relationship with parental figures. Kohut (1971) suggests that if the child receives appropriate mirroring and idealisation responses from parents, they are able to move through this phase of development successfully and develop a "mature form of positive self-esteem; self-confidence" (p. 215). However, if the child experiences parental neglect and their needs are not met, they become arrested at this stage and look to meet previously unmet childhood needs in adulthood (Kohut, 1971).

Several other authors have commented on the usefulness of lower levels of narcissism. Malkin (2015) reiterated that healthy levels of narcissism help to maintain confidence and self-esteem, build resilience, and fuel desire and ambition to reach goals. Morf and Rhodewalt (2001) argue that healthy narcissism enables us to maintain a positive view of ourselves, which helps with personal advancement, growth, and accomplishment. Stone (1998) comments on the "*Liebe* component" (p. 8), that 'normal' narcissism directs an individual to develop a realistic sense of attractiveness,

both physically and psychologically (such as morals/values, emotional maturity) compared to those around us. He notes that an ability to form and maintain healthy and satisfying relationships depend largely on these factors, and so it would be beneficial to devote a certain amount of attention to them. Therefore, while narcissism is a personality trait that is evident within nonclinical populations (Campbell & Miller, 2011) and can be defined as healthy, it moves into the pathological when an individual becomes self-centred, self-involved, and lacking in empathy (Lieberman, 2000).

Pathological Narcissism

Kohut (1971) believed that difficulties in development in grandiosity, idealisation, and connectedness lead to an underlying lack of self-cohesion, doubt, lack of confidence, underestimation of ability, and a vulnerable self-esteem (Kohut & Wolf, 1978). In these individuals, healthy expressions of grandiosity, mature goals, and a sense of connectedness are underdeveloped; the capacity to maintain self-esteem, form realistic goals, and empathise with others is lacking; and subsequently, they become focused on their deficiencies.

Vulnerability in self-esteem makes narcissistic individuals very sensitive to criticism or failure, leaving them prone to feelings of humiliation, shame, degradation, alienation, and emptiness. They may develop psychological defences to overcompensate for these feelings by creating a facade of grandiosity and success. These include fantasies of perfection and power, exaggerating achievements and talents, and avoiding situations and people that challenge these defences (Kohut, 1971). Threats to self-esteem involving criticism, defeat, or the failure of others to meet expectations tend to provoke hostility, contempt, shame, and rage (American Psychiatric Association, 1994; Baumeister & Bushman, 1998). Therefore, pathological narcissism can be seen as an attempt to regulate and maintain unrealistically high levels of self-esteem.

As narcissists' self-views often evoke negative reactions in others , they may rarely find affirmation, while their very vulnerability and instability makes affirmation particularly important. The combination of arrogance and vulnerability is a conflict that leads narcissists to defend and affirm their unrealistic self-concept.

The Overt Subtype

The most common reference to pathological narcissism refers to overt narcissism – also known as the arrogant, entitled, "thick-skinned", oblivious, exhibitionistic, or grandiose subtype. It is characterised by grandiosity, attention seeking, entitlement, arrogance, and little observable anxiety. Grandiosity is one of the dominating features, and involves repressing negative aspects of the self and distorting information. This leads to entitled attitudes and an inflated self-image, and engaging in fantasies of power, superiority, and perfection. Grandiosity is often expressed through exploitativeness, lack of empathy, intense envy, aggression, and exhibitionism (Ansell, Cain, & Pinkus, 2008). McWilliams (2011) suggests that the main conflict is with self-esteem and identity, with grandiosity overcompensating for self-consciousness and shame (Morrison, 1983). These individuals can be socially charming despite being interpersonally exploitative and oblivious to the needs of others (Caligor, Levy, & Yeomans, 2015). They can also mistakenly appear psychologically healthy due to the appearance of high levels of self-esteem (Wink, 1991).

Similarly, Caligor, Levy, and Yeomans (2015) introduce the 'high-functioning' narcissist, a variation within the overt subtype. As the name suggests, these individuals are very high-functioning, exhibitionistic, or autonomous; and occupy and aspire to positions of power, wealth, and prestige. They may be grandiose, competitive, attention-seeking, and sexually provocative, while continuing to function adequately and use their narcissistic traits to succeed. Because of their high level of functioning, these individuals may not appear to have a personality disorder, and so a diagnosis and relevant treatment can be easily overlooked. A preoccupation with appearing externally attractive means that they often develop an attractive and persuasive social manner, and are well liked by casual acquaintances and business associates who never get close enough to notice underlying feelings of emptiness or anger (Encyclopaedia of Mental Disorders, 2016). Unfortunately, narcissists in positions of high visibility or power, and especially in the 'helping' professions (such as medicine, education, or the ministry), have the potential to do great harm to others.

The Covert Subtype

Also referred to as the depleted, "thin-skinned", vulnerable, shy, hypervigilent, 'closet', depressed subtype, this narcissistic personality is characterised by inhibition, distress, envy, sensitivity to criticism (Caligor, Levy, & Yeomans, 2015), timidness, lacking in confidence, and struggling with feelings of insecurity (Arble, 2008). Interpersonally, these individuals are often shy and outwardly self-effacing, yet harbour secret grandiosity (Caligor, Levy, & Yeomans, 2015). They also tend to consciously experience feelings of helplessness, emptiness, low self-esteem, and shame (Ansell, Cain, & Pinkus, 2008). Covert narcissism is associated with lower levels of happiness, psychological well-being, optimism, self-esteem, and a sense of meaning and satisfaction in life (Wink, 1991).

Other defining features of the depleted narcissist include a shy and modest demeanour, hypersensitivity to criticism and failure, and shame related to unachieved goals. They often admire those who are successful, but secretly experiences envy of and resentment toward them (Wink, 1991). This individual's tendency to idealise others masks their largely unconscious feelings of grandiosity (Kernberg, 1986), making the diagnosis of the disorder especially challenging for clinicians.

A Comparison of the Two

Kohut (1971) proposes that overt narcissism results when a child's sense of self fails to integrate with the personality sufficiently, due to inadequate mirroring by parental figures. In an attempt to fulfil these unmet needs, the individual continues to express grandiosity and exhibitionism into adulthood. In contrast, covert narcissism results when a child does not learn to adequately regulate emotions, due to a lack of responsiveness by parental figures when the child is distressed (Kohut, 1971).

Despite distinct differences between the overt and covert forms of narcissism, they do show some of the same characteristics of entitlement, preoccupation with grandiosity, a lack of empathy, self-indulgence, and self-centredness (Ansell et al, 2009). According to Masterson (1993), the two subtypes can be differentiated by the nature of the "false self" that is expressed. More specifically, the grandiose narcissist devalues others and praises the self, whereas the depleted narcissist praises others and devalues the self. Additionally, while the grandiose narcissist seeks attention and

admiration from others, the depleted narcissist is preoccupied with unfilled expectations of the self. Consequently, both narcissists are absorbed in grandiose fantasies that are unrealistic - the depleted individual lacks initiative and self-confidence, while the grandiose individual overestimates their abilities (Wink, 1991).

Narcissistic Personality Disorder

The *DSM-5* (American Psychiatric Association, 2013) deals exclusively with overt narcissism. Older editions describe pathological traits, and a diagnosis of Narcissistic Personality Disorder (NPD) must meet at least five out of nine criteria including: grandiosity, fantasies of success or power, feelings of specialness, a need for excessive admiration, a sense of entitlement, interpersonally exploitative, lacking in empathy, envious, and arrogance (American Psychiatric Association, 2000). However, the *DSM-5* (2013) now includes impairments in personality functioning (self and interpersonal) alongside pathological personality traits. To diagnose NPD, a specific set of criteria must be met.

The first set includes significant impairments in self-functioning in either identity (reliance on others for self-esteem regulation; exaggerated self-appraisal) or self-direction (goal-setting based on approval-seeking; high or low expectations based on perception of self as exceptional or self-entitled). The second set of criteria includes impairments in interpersonal functioning in either empathy (lack of empathy or false empathy if relevant to self; over or underestimate own effect on others) or intimacy (superficial relationships serving self-esteem; lack of interest in others; a need for personal gain). The third set of criteria includes pathological personality traits in both attention seeking (need for attention and admiration) and antagonism (grandiosity, entitlement, self-centeredness, and feelings of specialness). The final criteria for NPD is that impairments in personality and behaviour are relatively stable across time and context, cannot be explained by normal development or socio-cultural environment, and are not due to the effects of substance use or general medical condition (American Psychiatric Association, 2013).

The *Psychodynamic Diagnostic Manual* (PDM; Psychodynamic Task Force, 2006) offers a description of the "Arrogant/Entitled" narcissist, which is similar to NPD as depicted in the *DSM-5* (American Psychiatric Association, 2013) and highlights the boisterous

and exploitative nature of this individual. Additionally, the *PDM* (Psychodynamic Task Force, 2006) also offers an alternative presentation of narcissistic pathology referred to as the "Depressed/Depleted" (covert) subtype.

Psychoanalytic Perspectives

Psychodynamic theorists suggest the origin of pathological narcissism is based on early life experiences which causes one to create a 'false self' (Winnicott, 1960) which must then be defended throughout the individual's lifetime. Freud (1914) was one of the earliest theorists to comment on narcissism, using the term to describe a stage of normal infantile development, established in part in how a child was raised by their parents, and the child's wish for the ideal mother-infant love. He used 'primary narcissism' to describe the infant's self-love ('narcissistic libido') which develops into the ability to love others ('object libido'). However, Freud believed that disappointments in object love (such as parental failures) may lead to withdrawal of interest/love (libido) from the world, resulting in 'secondary narcissism', which is a state of regressing back to infantile self-love (narcissism). He theorised that the development of narcissistic traits including self-absorption, self-love and self-elevation were used as attempts to gratify unfulfilled infantile needs.

Kohut (1977) also described narcissism as a normal and healthy aspect of infant development. According to Kohut (1977), a child's narcissism is maintained through mirroring (parents' display of validation, love and affection) and idealisation (the child's belief that the parent is perfect). In this way, idealisation increases the value of mirroring and the child's self-worth. Childhood narcissism eventually fades as mirroring and idealisation diminishes and are replaced by more realistic views. Kohut (1971) suggests that grandiosity and vulnerability develop when children do not receive appropriate mirroring and idealisation responses from caregivers. To cope with this unresponsive environment, horizontal or vertical 'splitting' occurs. Horizontal splitting allows individuals to maintain overt grandiosity while denying feelings of shame and low self-esteem, whereas vertical splitting results in conscious experiences of vulnerability, shame, and helplessness. Kohut (1971) argued that if narcissistic needs are not met in childhood, the individual maintains a defensive and unrealistic self-image and will continue attempting to meet them in adult relationships.

Kernberg (1974) proposes that narcissism originates in the separation-individuation phase of infant development, and is a defence against feelings of abandonment and rage associated with parental coldness, indifference, or hidden aggression. The child withdraws into a part of the self that the parents value (such as looks, ability or talent) which becomes hyperinflated and grandiose, and any perceived weaknesses are denied and repressed. This leads to conflict with dependency and autonomy as the child comes to believe that only they can be trusted and relied on, and therefore loved. Additionally, this results in a tendency to swing between extremes of grandiosity and feelings of emptiness and worthlessness.

Prevalence

According to the *DSM-IV* (American Psychiatric Association, 2000) the prevalence of NPD in clinical settings averages out to about 7%, compared with about 1% in the general population. The *DSM-IV* also reports that 50-75% of those diagnosed with NPD are men. Chou and colleagues (2008) found that rates of NPD were also generally greater among individuals who were highly educated, as well as separated, divorced, or widowed. NPD was also found to be more prevalent in younger generations, with the greatest decline in prevalence occurring after age 29 (Chou, Dawson, & Goldstein et al., 2008).

SUBSTANCE ADDICTION

First the man takes a drink,
Then the drink takes a drink,
Then the drink takes the man!

(Japanese Proverb)

It is considered normal and appropriate in our society to use certain substances, such as alcohol or caffeine, to modify mood or behaviour under certain circumstances. There are wide subcultural variations, and in some groups, such as Muslims, even social or ceremonial use of alcohol is unacceptable. In other groups, such as teenagers

and young adults, the use of illicit substances like marijuana, is widely accepted in social settings (Goode, 1970).

Substance Use, Abuse, and Dependence

Goldstein (2007) reflects that the pattern of use of substances is not a discrete condition but occurs on a continuum of severity. This is also reflected in the *DSM-5* (American Psychiatric Association, 2013) with severity of diagnosis based on number of criteria met, each representing consequences of use on relationships, obligations, and health.

Substance use pertains to an individual who uses drugs or alcohol at any level, though is commonly recognised as recreational use at the beginning of the continuum, with control, and without any significant consequences (does not meet any DSM criteria). Drug abuse refers to a maladaptive pattern of substance use, resulting in some loss of control, and limited but significant consequences (American Psychiatric Association, 2000). Drug dependence centres on a person's psychological and behavioural patterns related to drug use, and the subsequent impairments in functioning developed over time (Spross, 1999). This includes a loss of control over use and the presence of many significant consequences.

The major characteristic of addiction is an individual's diminished control over the use of a drug (Spross, 1999) where they are unable to reduce or cease use despite the repeated and negative consequences that result. Due to its compulsive, antisocial and self-destructive nature, addiction tends towards increased accidents, death, loss of employment, financial difficulty, crime, as well as stress and pain in the lives of addicts and their loved ones (Lee, Davidson, & Smith, 2010). Outcome studies generally show 40% to 80% rates of relapse among treated alcoholics or drug addicts (Moos & Moos, 2006).

Substance Use Disorder

Older versions of the *DSM* differentiate between substance abuse and substance dependence. However more recently, Substance Use Disorder in the *DSM-5* (American Psychological Association, 2013) combines these two categories into a single disorder measured on a continuum from mild to severe. According to the *DSM-5,* at least two

out of 11 criteria must be met in order to diagnose a Substance Use Disorder. The criteria include (1) taking larger amounts or for longer periods than intended; (2) unsuccessfully attempting to reduce use; (3) lengthy amounts of time obtaining, using, or recovering from the substance; (4) experiencing cravings; (5) failure to fulfil obligations at home, work, or school; (6) recurrent social or interpersonal problems; (7) reduced social, occupational, or recreational activities; (8) use in hazardous situations; (9) physical or psychological difficulties caused by substance use; (10) increased tolerance; and (11) withdrawal symptoms (including cross-addiction). On the severity continuum, meeting two to three criteria constitutes a mild disorder, four to five a moderate disorder, and six or more is considered severe.

While the DSM offers an observable and measurable set of criteria for substance addiction, the PDM (Psychodynamic Task Force, 2006) also recognises Addictive/Substance Use Disorder but focuses on the internal experience rather than a set of diagnosable criteria. The *PDM* suggests that drug choice may be used as a kind of self-medicating tool based on the substance's effect on affective states such as feelings of unworthiness, rage, depression, boredom, panic, and/or physical dependence. The importance of cognitive and relational patterns is also highlighted, including defences of denial and rationalisation of use, and neediness or devaluation of others.

The Disease Model of Addiction

For much of the twentieth century, theories of addictive behaviour and motivation were polarised between two models. The first model viewed addiction as a moral failure for which addicts should be held responsible and judged accordingly (Ahmed, Foddy & Pickard, 2015). In contrast, the second model viewed addiction as a specific brain disease, with biological, neurological, genetic, and environmental sources of origin (McLellan, 2002) occurring in response to chronic drug or alcohol use, and over which addicts have no choice or control. Advances in neurobiology have uncovered underlying disruptions in decision-making ability and emotional balance in those addicted to substances, which alters voluntary behavioural control (Koob, McLellan, & Volkow, 2016). As our capacity to understand neurobiology improved, the disease model of addiction became more scientifically accepted, dominating addiction research and informing public understandings (Ahmed, Foddy & Pickard, 2015).

However, the concept of addiction as a disease of the brain is still being questioned. This model challenges values about self-determination and personal responsibility that frames drug use as a voluntary, self-destructive act. The concept of addiction as a brain disease appears to excuse personal irresponsibility and criminal acts instead of punishing harmful and often illegal behaviours. Other criticisms include the failure to identify genetic variances or brain abnormalities that consistently apply to individuals in addiction, and to account for instances in which recovery occurs without treatment (Koob, McLellan, & Volkow, 2016).

Recovery Programmes

Alcoholics Anonymous (AA) is the most commonly used method of treatment for alcoholism (Robinson, 1996). The organisation describes itself as a fellowship of men and women who share their experience, strength, and hope with each other. The idea is that this support may help members and others to recover from alcoholism. The only requirement for membership is the desire to stop using alcohol, with a primary purpose to stay sober and help others to achieve sobriety (Alcoholics Anonymous General Service Board, 1992). According to AA (2016), the relative success of the programme is that an alcoholic in recovery appears to have an exceptional ability to 'reach' and help those who are still using.

The programme is known as "The Four Absolutes", including absolute honesty, absolute unselfishness, absolute purity, and absolute love (AA World Services, 1957). There are also three 'legacies' in AA including recovery (Twelve Steps); unity through anonymity, financial autonomy, organisation growth from attraction rather than promotion, and service to the organisation and people who need help. The heart of the programme is contained in the Twelve Steps, describing the experience of the earliest members:

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs (AA World Services, 1957).

While not a religious programme, members are encouraged to surrender the illusion of self-control and to draw on personal concepts of a 'Higher Power'. However, they are not required to accept or follow the Twelve Steps in their entirety, but are asked to keep an open mind (AA, 2016). There are a variety of meetings available to attend including both open (any interested individuals can attend) and closed (only those who identify as alcoholic are invited to attend), discussion (specific topics), Steps (explore the 12-steps), and study groups which study the 'Big Book' (AA's official text). New members are also encouraged to find a 'sponsor' – a member of AA with at least one year of sobriety, and who is willing to support and mentor (Robinson, 1996).

Narcotics Anonymous (NA) is based on the same concept, structure and organisation as AA, however expands to include all substance addictions. Although still based on the 12-steps, the focus shifts from the substance to psychological dependence, and the NA philosophy therefore reflects the idea that people turn to chemical substances to self-medicate. NA, like AA, believes that members are not personally responsible for having the disease of addiction, but are responsible for their recovery. Recovery

includes attending meetings, working the 12-steps, finding a sponsor, and helping other addicts to stay clean and study NA literature (NA, 2015).

Rational Recovery (RR) is another self-help programme for those suffering from substance use problems. RR is based on Albert Ellis's (1962) rational-emotive therapy, and is designed to help people deal with irrational thinking and negative emotions that contribute to the continuation of addiction behaviours. While RR also advocates abstinence, it differs conceptually from AA in that it maintains that people can control what they put in their body, and that it is irrational to believe that an individual must surrender to a 'Higher Power' in order to manage their life or their substance use (Allen, Estadt, Fenzel, & Reinert, 1993). The rationale then, is that people can maintain significant control over their emotions, behaviour, and any other disturbances.

Psychoanalytic Perspectives

Freud (1930) saw substance abuse as an 'impulse neurosis', characterised by the need for regressive, pleasurable states without inhibitions and prohibitions. Chein et al. (1964) introduced the ego-psychological point of view, describing addiction as an attempt to cope with painful emotions and overwhelming tasks and responsibilities in the outside world. Balint (1968) proposed that alcoholics use drinking to cope with vulnerability to rejection and aggressive feelings in close relationships. Beginning in the late 1960's, addiction has been seen as an ego function (Wurmser, 1974; Khantzian, 1985), that is, where particular substances are chosen and used as a means to manage an individual's most intolerable emotions, which vary from person to person. Other ego functions attributed to drug use have been their role as object substitutes to activate positive impressions of self and others (Kernberg, 1975), a substitute for a defect in psychological structure arising from an inadequate idealised self-object (Kohut, 1971), to repair a lost sense of an idealised object or grandiose self (Wurmser, 1974), and to calm negative affective states in order to avoid overwhelm (McDougall, 1984).

Self-psychology has become a popular means of conceptualising addiction from a psychoanalytic perspective. Kohut (1977) theorised that in the course of healthy development, children need empathic caregivers who can initially perform self-soothing, affect regulation, and self-esteem maintenance for the child until they learn

to do this for themselves; and to recognise, validate and appreciate the child's mirroring needs. Deficits in these areas may result in feelings of inadequacy, depression, and anxiety; and a constant need for validation and attention (Kohut, 1971). Kohut (1977) views addiction as an attempt to compensate for these developmental deficits in the self. He believes that substances become the previously failed self-object, and that "by ingesting the drug he symbolically compels the mirroring self-object to soothe him, to accept him... [it] provides him with the self-esteem which he does not possess" (pp. vii-viii).

Other theorists saw substance use as a means of achieving a sense of internal emotional control over intolerable feelings (Khantzian, 1985), a substitute for a lost person (Krystal & Raskin, 1970), defiance against self-punishing thoughts (Wurmser, 1974), or as a solution for narcissistic injury and shame (Kohut & Wolf, 1978). More recently, Dodes (2009) suggests that addiction and addictive behaviours are preceded by a feeling of overwhelming helplessness or powerlessness resulting from early deprivation or attachment failures, conflicts around control and competitiveness with corresponding feelings of shame, or psychopathology.

Prevalence

New Zealanders as a population have some of the higher substance-use rates in the developed world. Survey results show approximately 26% of those over 14 years old use alcohol at least three times per week, 50% of those over 16 years old have used illicit substances (Ministry of Health, 2007), with approximately 3.5% of the population (about 150,000 people) suffering from substance addiction (Mental Health Commission, 2008). Alcohol and drug use also incurs approximately six billion dollars in tangible and intangible costs (such as road accidents, health care, injury, premature death, crime) per annum (Ministry of Health, 2008). The pervasive use and abuse of drugs in the general population, and the clearly established relationship between addiction and psychological disorder (and crime), emphasise the importance of developing a deeper understanding to improve efficacy of prevention, diagnosis and treatment in the criminal justice, mental health and addiction service systems.

COMORBIDITY OF NPD AND SUDS

Comorbid studies of NPD and addiction are inconsistent, ranging from 0-18% in alcohol studies (Bottlender, Soyka, & Preuss, 2006) and 1-19% in non-alcohol (other substances) studies (Fridell & Hesse, 2006). Vaglum (1999) attempted to bridge these inconsistencies by taking average prevalence rates of NPD from a number of studies including 14 samples of individuals with substance use disorders. This revealed an average prevalence of 6.8% in substance addiction samples, which was more than double the clinical samples (3.6%), and more than 45 times higher than in community samples (0.15%).

CHAPTER SUMMARY

In this chapter I have presented an overview of literature, providing the background and context for the research. This included an introduction to narcissism, with an overview of healthy and pathological definitions, overt and covert subtypes and a comparison of the two, Narcissistic Personality Disorder (NPD), psychoanalytic perspectives, and prevalence. It also included an introduction to addiction, with an overview of use, abuse and dependence; Substance Use Disorder (SUD), the disease model of addiction, recovery programmes, psychoanalytic perspectives, and prevalence. Finally, this chapter provides a brief overview of the comorbidity of narcissism and addiction.

The next chapter introduces the methodology for this dissertation, which is based on the hermeneutic philosophy. Included is the rationale for engaging in a qualitative study, from a hermeneutic perspective, including the importance of research bias, and personal reflections on my journey in a parallel process.

CHAPTER THREE: METHODOLOGY

As I have significant interpersonal experience with pathological narcissism and addiction, and my research is based on deepening the understanding of human behaviour, beliefs, attitudes and interactions, I am undertaking a qualitative study from a hermeneutic perspective. This methodology will enable me to engage deeply with the relevant literature while taking context and my own subjectivity into account.

Qualitative Study

Due to their finite and structured nature, Boell and Cecez-Kecmanovic (2010) argue that systematic reviews are not suitable for most literature reviews in the humanities and social sciences. However, Pearson (2004) states that they can be modified to include other kinds of data, using interpretive methods to make sense of complex dynamic phenomena such as beliefs, experiences, attitudes, behaviour, and interactions (Smythe & Spence, 2012). A qualitative approach views data more extensively, strengthened and enhanced by subjective experience. Using my own experiences in conjunction with the data can encourage new aspects of the study to emerge (Jena, Kalra, & Pathak, 2013). The qualitative methodology is interpretive in its foundations, supporting the view that there are many truths and multiple realities (Biklen & Bogdan, 2003). Working and coding the data, and repeating this process in subsequent iterations (as a hermeneutic approach), will help me to explore these various realities - which may or may not differ from my own ideas - gaining a deeper understanding of the literature, and finding new meaning in it.

Hermeneutics

The word 'hermeneutic' derives from the Greek verb *hermenuein*, which in its most general translation, means 'to interpret' (Ihde, 1990). In Greek mythology, Hermes was the messenger of the gods, "who brings a word from the realm of the wordless" (Ihde, 1990, p. 325). Through translation and interpretation, Hermes served to bridge the gap between gods and humans, communicating new meaning and understandings between the two. As such, I too wish to bridge the space, not only between literature and reader, but also between pathological narcissism and addiction.

Hermeneutic philosophies have existed for centuries, originally directed towards understanding biblical and sacred texts (Diesing, 1991). Current hermeneutic thought derives from the works of Heidegger and Gadamer, and looks at methods of understanding in the human sciences (Smythe & Spence, 2012). In research, the hermeneutic perspective is a way of engaging with and interpreting qualitative data, with understanding developing through the movement back and forth between researcher and subject area (Smyth & Spence, 2012). Unlike empirical research, the aim of hermeneutics is to "provoke thinking" expanding outward, rather than reducing to a single truth or understanding (Smythe & Spence, 2012, p. 14).

The hermeneutic circle was the term Heidegger developed to refer to the process of re-interpreting relevant literature rather than coming to a final interpretation, ideally resulting in a deeper and more comprehensive understanding (Boell & Cecez-Kecmanovic, 2010). As individual parts relate to the understanding of a larger whole, and vice versa, the understanding of a text is never isolated, but instead interpreted in the context of other texts. Understanding of the relevant literature, then, is influenced by each new paper read and interpreted. Reviewing the literature is an iterative process form the whole of the relevant literature, to specific texts, and back to the body of relevant literature (Boell & Cecez-Kecmanovic, 2010). As I engage in this process, my understanding of the whole will change together with the meaning of its parts.

Researcher Bias

Gadamer (1976) suggests that all understanding is interpretive, and that from a hermeneutic perspective, my own subjectivity and prejudices need to be recognised and valued with careful attention to how they may impact on the research. I expect that given my own painful experiences of growing up with a narcissistic parent, my biases could have a significant impact on the process if not acknowledged consciously. Diesing (1991) links the hermeneutic approach to psychoanalysis, describing how the meeting of transference and countertransference in the therapy room is similar to the meeting of subjectivities of the reader and text in hermeneutic research. In this way, when I read a text, I will project onto it my own prior understandings, and make new understandings combining what I already know with what I am reading. In a literature review, the impact of my prior understandings and experiences on some texts may

spark inspiration, whereas others may be easily bypassed (Smythe & Spence, 2012). Circular in motion, this process repeats as I continuously project and interpret, all the while new understandings and ideas emerging (Ezzy, 2013). As long as I am mindful about wanting to develop new understandings, I will be able to create the space and awareness needed for them to emerge (Ezzy, 2013). Gadamer's ideas encourage the acknowledgement and acceptance of personal biases because they stimulate thinking on an issue (Malpas, 2013). I see this as a process of clarifying my own viewpoints and progressively modifying or discarding them as my research proceeds.

Heidegger (1995) refers to this process in three ways. *Fore-having* is the understanding we already have, that allows us to make sense of our current experiences. In my case, my experiences with narcissism and addiction drew me to the research topic and helped to shape my research question. *Fore-sight* brings understanding in advance, that is, expectations based on the understanding we have. I had an idea about which key words to search, relevant databases, texts and such; but still needed to be open and proactive towards the unexpected so as to allow space for growth beyond my expectations. *Fore-conception* is having a preconceived idea of what will be encountered in the process; such as links made, inclusion/exclusion, or outcome. Indeed, I noticed that I had pre-formed hypotheses about my research and caught myself conducting the research in a way that supported them. However, aware of engaging in this process allowed me to return to a more open stance.

Reflections

Smythe and Spence (2012) suggest that the researcher in a hermeneutic study is the starting point when examining the meaning of a text, standing "at the 19 crossroads of all their fore-understanding" (p. 16). I approach this research with a wealth of experience after having, for the most part of my life, lived or maintained a relationship with my father, who is overtly narcissistic and alcoholic. Looking back, it is interesting to reflect on the parallel process of the hermeneutic encounter. In my undergraduate study, I began learning about the Narcissistic Personality Disorder and, with my own experiences in hand, began projecting onto the texts (ie, finding my father in the NPD diagnosis), making meaning and forming new understandings about what this diagnosis meant to me (ie, myself as less responsible for my father's behaviours towards me), as well as about myself and my relationship with my father (ie, accepting

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the reality of a narcissistic parent). More than a decade later, I began my placement at an addiction clinic, and very quickly, once again began projecting my own experiences onto my learning there (ie, again, finding my father in the addiction diagnosis), forming new and deeper understandings of our relationship (ie, manipulation and enabling). It seems only fitting that in exploring the relationship between addiction and narcissism, I would engage yet again in the hermeneutic process. According to Smythe and Spence (2012), to attempt to be an objective observer in my research process would not only be impossible, but would also invalidate my existing understanding and limit my capacity to engage with the literature as a full "conversational partner" (p. 16). After all, "It is the researchers' relatedness to the literature that enables them to see the potential insights that lie within" (Smythe & Spence, 2012, p. 17.)

CHAPTER SUMMARY

This chapter introduced the methodology for this dissertation, which is based on the hermeneutic philosophy. Included is the rationale for engaging in a qualitative study, from a hermeneutic perspective, including the importance of understanding and reflecting on research bias, and personal reflections on my journey in a parallel process.

The next chapter follows my progress as I engage with in the research process. This journey begins with sourcing texts, sorting and selecting literature, covers the inclusion/exclusion criteria, and discusses my application of the hermeneutic methodology.

CHAPTER FOUR: METHOD

The method of this dissertation is a literature review. I have chosen this method partly as a result of an earlier project where I completed a brief thematic analysis on countertransference with the grandiose narcissist client. I had considered expanding on this thematic analysis for this research project, however, when reflecting on my own personal experience of addiction and NPD, I considered that the numerous more subtle, yet significant, components which make up these disorders may be lost in the coding process. In addition, I wanted to make meaning beyond the therapist experience, and expand rather than refine current contributions to the literature. For these reasons, I felt a literature review to be more fitting.

Because of my own experiences with narcissism and addiction, I naturally have my own biases in relation to the subject matter. Incorporating this mindfully and with openness has the potential to facilitate a deepening of meaning making in the research process. This, along with bringing in and making sense of my own thinking and reflections on the literature, and vice versa, is reflective of the hermeneutic approach.

Sourcing Texts

According to Smythe and Spence (2012), the aim of a hermeneutic literature review is to locate data that is of interest and generates new thinking, using the researcher's subjectivity. The task, then, is to bring an open and curious attitude to the various texts in order to identify those that I was drawn to. As such, I searched for literature that resonated with me, that engaged my interest and provoked my thinking.

To begin my search, I identified databases that would most likely provide access to relevant literature. These included:

- AUT Library Search
- AUT Databases: PsycARTICLES, PsycBOOKS, PsycEXTRA, PsycINFO, Psychoanalytic Electronic Publishing (PEP)
- AUT Research and Theses
- AUT eJournal Titles
- Worldwide Web: Google Scholar

I identified key words that would most likely connect with relevant material. My research question *"How addiction contributes to pathological narcissism"* seeks to explore the significance of the presence of addiction in the pathological narcissist. After an initial search with a general spectrum of key words yielding an overwhelmingly broad range of non-specific and unrelated material, I refined the search utilising combinations of key words including "narcissis*", "drug", alcohol*", "substance" "dependence", "addict*", "abuse". An asterisk was included for possible suffixes of keywords to make the search more inclusive and efficient – for example "narcissis*" would include literature using the term "narcissistic" and "narcissism".

In addition to a systematic search, I also checked reference lists of articles and chapters, unpublished sources such as dissertations and theses, and manually searched AUT library shelves in related subject areas.

Below is a table of the initial search results of relevant texts, in the order searched:

Database	Total results	Relevant results not already sourced*
AUT Library Search	96,617	6
PsycEXTRA	0	0
PEP	2	0
AUT Research and Theses	177	2
AUT eJournal Titles	701	3
Google Scholar	68,370	1

Table 1. Initial Search Results

*This refers to new articles which were relevant but had not already been sourced through previous searches (ie, duplicated articles were excluded).

PsycARTICLES, PsycBOOKS and PsycINFO were all automatically included under the general AUT library search tool and therefore not searched individually.

From the initial search I read abstracts and introductions to articles, books and chapters in order to determine relevance to the topic. I then printed sections of dissertations or theses and checked reference lists to source additional relevant literature. During this process, I began noting any ideas, key words, journal titles, or publications which captured my curiosity. I found several more highly relevant

articles, some of which needed to be sourced through the AUT library interloan system. I sucessfully obtained four of the seven requested. This brought my total sources to 16.

Because the subject-specific sources identified through this search process were relatively few, I broadened the scope of investigation to include more generalised articles (for example, characteristics of addiction and characteristics of narcissism), which could then be cross-referenced at a later stage of analysis. These were put aside to be read in full and sorted. Key words elicited based on initial articles found, included "traits", "characteristics", "personality", "Narcissistic Personality Disorder", "comorbid", "dual diagnosis" and "cluster B". For subsequent searches, I also used commands known as Boolean operators, which combine keywords to refine database searches, including "or" and "and". An example of this is as follows: "addict*" AND "narcissistic" AND "characteristics" OR "traits". Through this process, I obtained an additional 38 articles.

As I broadened my search I also wanted to find material exclusive to narcissism and addiction as reference points for understanding each subject area. As there was an overwhelming range of material for each, I chose sources which represented the general consensus of understanding on the topic, such as *The Handbook of the Psychology of Narcissism: Diverse Perspectives* (Besser, 2014) which included a broad range of known theories and ideas. I also selected articles which offered alternative or lesser-known models for comparison, such as *Alternative Models of Addiction* (Ahmed, Foddy, & Pickard, 2015). I selected a total of seven sources for this purpose, however the entirety of sources selected for the research contributed towards my understanding of addiction and narcissism.

Sorting and Selecting

Initial reading of titles and abstracts allowed me to determine whether the material was relevant or of interest, and a total of 54 sources were selected to be collated for sorting and reading. With a large number of sources, Boell and Cecez-Kecmanovic (2014) suggest *orientational reading* – that is, structuring and organising the material by reading abstracts, introductions and conclusions. Through this process, I sorted the literature into five groups based on the themes which emerged. I then skim-read each

source and sorted it into 'yes' and 'no' piles based on whether I chose to keep it, discard it, or redistribute it into another group. I based this decision on each source's relevance to the topic, whether it was duplicate material, and whether it met the inclusion/exclusion criteria. Additionally, larger groups were also divided into sub-groups of themes for a more refined structure. This can be shown in the table below:

#	Relevance	Theme	Sub Theme	Total	Yes	No
1	High	Narcissism and Addiction		16	14	02
			General	(09)	(07)	(02)
			Surrender	(03)	(03)	(00)
			Theory	(04)	(04)	(00)
2	Medium	Narcissism and personality		11	06	05
3	Medium	Addiction and personality		21	12	09
			General	(08)	(05)	(03)
			Specific	(12)	(08)	(04)
4	Low	Narcissism (Reference)		04	04	00
5	Low	Addiction (Reference)		03	03	00
		TOTAL		54	39	16

Table 2. Themes and Sub-themes of the Data

This left me with a total of 39 sources, including 32 relevant to my topic and seven as reference materials. As I began to read my way through each theme and/or sub-theme, I continued to note more specific ideas, concepts, or topics that arose (particularly any new knowledge or information), any relevant citations and references which lead me to new sources, as well as my personal responses to the material. Despite contributing to an overall deepening of my understanding of the topic, I chose not to include in the body of work in this literature review predominantly because it related to only one isolated aspect of the research topic. Sources included articles, song lyrics, poetry, and images.

An important part of the search process followed the presentation of my dissertation progress to fellow students and lecturers from the AUT psychotherapy department. It

was reflected back to me that it appeared I had only focused on one aspect of narcissism – that is, the overt subtype, despite having already made a conscious attempt not to narrow my focus. At the time, I defended my position with the fact that almost all the literature I had sourced focused on the overt subtype, was based on *DSM* definitions of narcissism, and that this was beyond my control. However, after spending some time thinking about this, discussing it with my supervisor, and considering *why* this was the case, I was able to bring myself back to a place of curiosity and openness. It seems that although I had not been discounting studies pertaining to covert narcissism, I hadn't specifically identified this area as lacking either. I was then able to source other relevant research which may not have contributed significantly to the body of the work but did contribute towards my overall understanding and enable me to think more critically about the absence of studies at this stage of the research.

As the search process progressed, and as my array of sources continued to increase and decrease with reading and sorting, I continued to divide the material into smaller groups of sub-topics as a means of mapping and classifying the literature. I was confident in exiting the iterative process of the search when new articles appeared to be introducing familiar arguments, research results, authors, and concepts (Ellis & Levy, 2006).

Inclusion/Exclusion Criteria

Although I specifically sought any sources which discussed both narcissism and addiction, I found very little. I therefore included all relevant sources to broaden the possible links between the two.

My specific interest in this dissertation is the relationship between pathological narcissism and substance dependence, therefore I excluded texts referencing healthy or 'normal' levels of narcissism, as well as all other forms of addiction (such as internet, gaming, shopping, sex). Narcissistic traits in children and adolescents may be explained as part of normal development (Adler-Tapia, 2012) so I only included studies of individuals aged 18 and above. I also excluded any non-English texts, unless already translated.

Applying the Methodology

I went into my initial search impatient, keen to delve into a topic I am so passionate about. It was not until I was already into the search that I was able to step back to observe the process in which I was engaging – just as the hermeneutic approach requires. It was then that I became aware of an agenda, a previously unconscious hypothesis that I had been attempting to prove – that grandiose narcissism indeed has a significant relationship with addiction. I then realised that I had been excluding two kinds of relevant texts in the search: those which challenged that hypothesis (ie, research that did not support a positive association) and those that did not reflect my personal experience (ie, literature pertaining to covert narcissism). It was at this point that I recognised the need to repeat the search, with a conscious desire for new ideas and understandings to emerge (Ezzy, 2013).

Once the search process had concluded, I began to engage with the material – immersing myself in reading and reflecting. I found more sources through relevant or interesting in-text citations or when new information arose, and relevant sources continued to expand. Although this at times, felt overwhelming and I was tempted to end the sourcing process, it did lead to significant findings and development of the topic. For example, near the end of the reading process, I found a single reference to a study on covert narcissism enabling me to source two texts on the subject (Karakoula & Trilvia, 2016), which had otherwise been completely absent from the sourced literature. Unfortunately, despite an extensive search, I was unable to source an English version of one of the texts (Bobes, Ripoll, & Salazar, 2010). The remaining text used a self-report questionnaire typically used to measure covert narcissism, which then provided me with a clue for further searching, and a new avenue to explore.

This obvious lack of literature on covert narcissism and addiction was, on the one hand, not surprising to me as I myself had not initially consciously considered its relevance or importance. However, on the other hand, once I did become aware, I suddenly expected to find 'answers'. This was not the case, but it did ignite an interest in the topic. Smyth et al. (2008) reflect that "we do not plan what must be thought about, rather we are held (or not held) by thinking that demands to be within us…" (p. 1393). I started thinking about *why* covert narcissism was lacking, and around the same time started noticing the repeated references to other comorbid diagnoses in

addiction, and I began to wonder about the impact of differential diagnoses on those with narcissistically organised personalities. Considering that covert narcissism was initially completely absent in my research just as it was absent in the available literature, it was interesting that understanding this absence became a focal point for some time. A seed had been planted and it was growing.

The process of searching, sorting, reading, reflecting and writing, was never clearly defined in my process of undertaking this research. All were mixed and muddled like a giant multi-coloured rubber-band ball – tightly linked, held together, and hard to untangle. I expressed my struggle to my brother, who (once again) asked "how do you eat an elephant?" Knowing the answer was *one bite at a time*, I engaged in a more methodical process, working my way through the literature piece by piece, untangling the muddle of rubber bands, while still placing them together as a whole. I also began mapping ideas, themes, subthemes, reflections, and considering if and how each may be related. This helped to anchor me in what felt like an overwhelming amount of information.

During the process, I also noted my personal responses to the material. I found that when my personal responses were limited, I delved more into the methodical aspect of my process, and my writing reflected a more clinical perspective (heavy on data, lacking personal responses). When I was able to engage with my personal responses to the material, I struggled to articulate them in the writing, and experienced 'writer's block'. This (not so coincidentally), was significant around times that I had contact with my father. I experienced a sense of feeling saturated and suffocated; having been reading, writing, thinking, reflecting, living and working with narcissism and addiction in both my personal and professional life. I also wondered if this were a typical countertransference response to the narcissistic alcoholic. When I was able to 'come up for a breath', I engaged in a new search for the therapist's experience with this client population. I was frustrated to come back empty handed, once again noticing the lack of research in such a refined topic. Instead, a colleague suggested I add reflections on my own experiences in working with this client group, and thus contribute to the subject area.

Aside from the writing being meshed with other processes of the research project, it was a circular process itself. I would write a chapter, a page, a paragraph, or even a

few words; but this was never set in stone. As I continued to read and note my reflections, I wrote and rewrote as my understanding deepened, as ideas grew and developed, and as I continued to work the material. The iterative process of moving between the parts and back to the whole (Boell & Cecez-Kecmanovic, 2010) was, for me, especially evident as my thoughts were eventually translated onto the page, developed, redeveloped, and developing – moving from abstract to concrete. There was a sense of the work not feeling real, or whole, complete, full, until it was there in front of me on the computer screen. Interestingly, this felt similar to experiences I had with my father – a sense of inadequacy until there was evidence to the contrary.

Eventually, I reached a point where I felt the data had been synthesised in a meaningful way, where new ideas were spiralling the research horizontally (outward) rather than vertically (deeper). Although these new ideas indicated other important areas for further/future research, I felt confident that they were superfluous for the purposes of this study. It was at this point that I realised I was nearing the end of this research project.

CHAPTER SUMMARY

This chapter followed my progress as I engaged with the research process. My journey began with sourcing texts, sorting and selecting literature, covered the inclusion/exclusion criteria, and discussed my application of the methodology. I have discussed my personal reflections, and how they impacted on my ability to engage with the research.

The next chapter is a review of the literature, presented in themes and subthemes. This includes a discussion on whether narcissism precedes addiction or addiction precedes narcissism, the co-occurrence of narcissism and addiction, differential diagnoses, common personality factors, the self-medication hypothesis, the relationship between surrender and narcissism in Alcoholics Anonymous, and a study on covert narcissism. Additionally, I discuss limitations of the available literature, and contribute to the subject area using my personal experience of working with narcissistic addicts.

CHAPTER FIVE: FINDINGS OF THE STUDY

Introduction

In my review of the literature, I found that the data was viewed from two main perspectives: a more clinical focus from the addictions perspective and a more psychodynamic focus from the narcissism perspective. Much of the literature on addictions was based on measurable data, such as empirical studies using personality inventories, observable behaviour, and clinical descriptions of narcissism and substance-dependence. On the other hand, literature on narcissism tended to be theory-based, such as the aetiology of narcissism and substance dependence, and underlying core issues. I found a complete lack of research on the interpersonal dimension of working with addicted narcissistic clients, such as the therapeutic relationship, transference, or countertransference. The different perspectives sometimes complemented each other and I found several similarities between the two, such as risk factors related to specific personality characteristics, the self-medication hypothesis, and the increased risk of relapse for narcissistic addicts. However, I noticed they also conflicted at times, which raised questions such as whether a narcissistic personality may predispose an individual to addiction, whether addiction leads to the development of narcissistic traits, or if the two are independent. As I noted in the previous chapter, neither set of literature contained much material relating to covert narcissism.

THE CHICKEN OR THE EGG

One of the conflicting ideas between the narcissism and addiction perspectives relates to the aetiology of the disorders. The literature on addiction typically viewed addiction from a disease perspective, which is genetically and biologically predetermined. From this perspective, narcissism is a secondary function and is viewed as the result of engaging in addictive behaviours. However, the literature on narcissism (predominantly by psychoanalytic writers) viewed addiction as a narcissistic disturbance, resulting from early childhood trauma and subsequent personality development which makes an individual prone to addictive behaviours. Thus the question is raised – 'which came first, the chicken or the egg?

The primary personality disorder model proposes that pathological personality traits contribute to the development of a substance use disorder (van den Brink & Verheul, 2005). Although early studies failed to identify a unique type of pre-addictive personality (Barnes, 1979; Cox, 1987), more recent studies have found traits such as aggression, impulsivity, conduct problems (Sher & Trull, 1994), novelty seeking, harm avoidance, and reward dependence (Bohman, Cloninger, & Sigvardsson 1988) were associated with a significant increase in the risk of addiction in adulthood. Psychoanalytic writers suggest that early childhood narcissistic injuries may predispose individuals to addictive behaviour (Tahka, 1979; Dodes, 1988; Kohut, 1971). Dodes (1988) believes that as a result of not having emotional needs met in early childhood, an individual looks externally to satisfy these needs, and therefore becomes prone to using alcohol or drugs for this purpose. Brook, Whiteman, Finch, and Cohen (2000) found that secure attachment in early childhood resulted in the development of greater responsibility, less rebelliousness, and intolerance of deviance in adolescence. Adolescents with these characteristics were less likely to associate with drug-using peers and were less likely to use drugs in their 20s.

Examples such as these suggest that particular disruptions in childhood and adolescent development may lead an individual to be predisposed to substance use particularly when the individual has difficulty in self-regulation. This is also consistent with aspects of a narcissistic personality (Lukowitsky & Pincus, 2010). The individual, perhaps, experiences a kind of deficit which they seek externally to 'fill' and substances appear to fit this need adequately. I imagine for the alcoholic who consumes a large amount of alcohol (as opposed to inhaling smoke or using a small amount of substances intravenously), the large quantity can serve to physically and emotionally fill the experienced void.

However, the primary substance use disorder model (van den Brink & Verheul, 2000) proposes that substance abuse contributes to the development of personality pathology. Family studies have shown that substance use disorders repeat in families, raising the possibility of a genetic predisposition to substance addiction (Aguilar-Gazioet, Mehta, & Merikangas et al., 1998). Bernstein and Handelsman (1995) suggest that social peer group norms may influence the use of substances, independent from an individual's personality pathology. This may be particular to more deviant social

culture, such as 'the naughty boys' in class or children who grow up in an environment where deviance is the norm. As a child, and particularly as an adolescent, I remember the pressures of trying to 'fit in', that being accepted amongst peers felt more important than following 'adult' rules. Indeed, there were times when I engaged in activities as a child (such as smoking cigarettes or drinking alcohol) which did not fit with my own moral code. The fear of rejection by my peers far outweighed the fear of being caught and disciplined by authority figures.

Conclusion

It is extremely difficult to separate behaviours resulting from substance use, from persistent behaviour patterns, particularly among individuals with chronic substance abuse histories (van den Brink & Verheul, 2005). Therefore, there is no clear answer to the 'chicken or egg' predicament. I wonder about personality pathology which goes undiagnosed until addiction brings an individual into treatment – such as is frequently the case for those with overt narcissistic personalities. This may result in greater (and incorrect) support for the primary substance use disorder, rather than the underlying NPD. Most of the literature sourced for this research project suggests that personality predisposes addiction, or at the very least increases the risk of an individual using and abuse substances. However, it is also important to consider that personality pathology and substance addiction may be mutually exclusive, or that more than one model may help to explain the presented pathology. Coming from a psychotherapy background, my instinct is to support the primary personality model. However, I also consider how easily I related to the idea of peer pressure contributing towards learned behaviour in adolescence. I therefore speculate if the answer is simply that it is different for different people, in different circumstances. Regardless of the answer to the age-old question of which came first, this does not answer why some individuals with the same (or similar) circumstances go on to develop narcissistic personalities and/or addiction and others don't.

CO-OCCURRENCE OF NARCISSISISM AND ADDICTION

Once again, both the addictions and narcissism perspective offer varying contributions. The addictions perspective considers the co-occurrence of disorders as 'dual-diagnosis' which includes Substance Use Disorder (SUD) and any other diagnosis, with both being

seen as separate. From the narcissism perspective, the co-occurrence of disorders is considered 'comorbidity', typically with a primary and secondary diagnosis (or diagnoses) which may be related.

Dual Diagnosis (NPD in those who are addicted)

The literature consistently stated that the most frequent dual diagnosis is the co-occurrence of SUDs and personality disorders. Preuss et al. (2009) reported on figures ranging from 25% to as high as 93% for comorbid alcohol dependence and personality disorders. However, more typical rates range from 30-75% (Ball, Kranzler, & Poling et al., 2000). The vast range may reflect differences in the particular populations, admission criteria, types of treatment, and diagnostic tools. The prevalence of personality disorders in community samples of substance abusers was found to be at least three times higher than in those who do not abuse substances (Van den Brink & Verheul, 2004). This supports the link between substance use disorders and personality disorders.

The relationship between substance use disorders and personality disorders appears to be especially relevant to 'Cluster B' personality disorders – which, according to the *DSM-IV* (American Psychiatric Association, 2000) are characterised by erratic behaviour and emotions, and includes the borderline, antisocial, histrionic, and narcissistic personalities. In a clinical sample of 1079 addicted participants in treatment, Preuss et al. (2009) found that co-occurring personality disorders were present in 60.4% of participants, with a slightly higher rate reported for men (61.8%) than women (57.7%). NPD ranked third most prevalent, present in 18.6% of the sample. Men were more likely to have narcissistic and antisocial personality disorders, whereas more women were diagnosed as borderline. This shows that while not the most common personality disorder among addicted clients, NPD in still relatively frequent particularly among males.

In summary, the literature showed that SUD's frequently co-occurred with personality disorders, and in particular borderline, narcissistic, and antisocial personality disorders. Within this range and within the context of this dissertation, men were more likely to be narcissistic and addicted to substances.

Comorbidity (Addiction in those with NPD)

According to the literature, NPD is frequently comorbid with other disorders, particularly SUDs and other personality disorders (Chou et al., 2008). Comorbid studies of NPD and addiction are inconsistent, ranging from 0-18% in alcohol studies (Bottlender, Preuss, & Soyka, 2006) and 1-19% in non-alcohol (other substances) studies (Fridell & Hesse, 2006). Vaglum (1999) attempted to bridge these inconsistencies by taking average prevalence rates of NPD from a number of studies including 14 samples of individuals with substance use disorders. This revealed an average prevalence of 6.8% in substance addiction samples, which was more than double clinical samples (3.6%), and more than 45 times higher than in community samples (0.15%). This shows a significant difference between the populations. When specifically accounting for lifetime NPD as a primary disorder, Chou and colleagues (2008) found mood disorders (17.4%), anxiety disorders (15.2%) and SUDs (11.8 %) to be the most prevalent comorbidities. Among these broad categories, rates of NPD were greatest among respondents with drug dependence. The study also revealed that substance use (not dependence) was very high among respondents with NPD, with approximately 40.6% of participants using recreationally. With such a high percentage of recreational substance use, it is no wonder that many will go on to develop a SUD. Because these figures are based on lifetime NPD diagnosis only (representing a specific group of narcissistic individuals) I wonder whether considering non-lifetime associations of NPD would increase the prevalence even more.

Pinkus and Lukowitsky (2010) report that overt and covert narcissistic subtypes are associated with different forms of comorbidity, with depression and anxiety being more common in the covert narcissistic group, and grandiose traits relating more to substance abuse and comorbidity with antisocial personality disorder. This may indicate why rates of narcissism vary significantly, with each subtype perhaps being overlooked in favour of a more obvious differential diagnosis. However, as previously mentioned, studies on covert narcissism are severely lacking in the available literature.

Conclusion

Studies have revealed an inconsistent range of prevalence rates and a lack of studies on covert narcissism, making estimates somewhat unreliable. However, what has

been shown consistently is that relative to many other personality disorders, Substance Use Disorders and NPD co-occur frequently, and in particular among men. While much of the literature supports this link, I wonder why and how they are related. It may be difficult to determine whether a single set of personality traits is related to all types of substance use disorders, whether different personality traits are related to different types of substance use disorders, or whether comorbid substance use disorders mediate the relationship between personality and addiction. However, perhaps some insight into the finer details of the relationship can provide clinicians with a deeper understanding so they are more equipped to working with this client population – or, in a perfect world, help lower rates of addiction by working effectively with narcissistic clients prior to them moving from substance use into substance dependence.

DIFFERENTIAL DIAGNOSES

With such an obvious lack of research on covert narcissism, and the high co-occurrence of Cluster B personality disorders with SUDs, I began thinking about the possible impact of a differential diagnosis. A range of differential diagnoses for NPD have been identified including antisocial, depressive, obsessive-compulsive (McWilliams, 2011) borderline and histrionic personalities, grandiosity in mania or hypomania episodes (American Psychiatric Association, 2013); and anxiety, substance use, and bipolar disorders (Caligor, Levy, & Yeomans, 2015) which cover a wide range of personality overlaps.

The high comorbidity among personality disorders, especially Cluster-B disorders (narcissistic, antisocial, borderline and histrionic personalities), raises questions about whether they are separate disorders, or slightly different manifestations of the same underlying personality. Indeed, Lubman et al. (2004) proposes that the regions of the brain involved with impulsive behaviours underlie both addictive processes and 'Cluster B' disorders. Not only might this suggest a common feature among Cluster B personality disorders, but also their link with SUDs. The range of differential diagnoses and the high rate of comorbidity make understanding symptomology and diagnosis more difficult. For example, it may be unclear whether anxiety and depression are reflective of a comorbid diagnosis (SUD and depression), or are part of the personality pathology (covert narcissism).

Antisocial Personality Disorder (ASPD)

The literature noted significant comorbidity between the ASPD and NPD (for example, Gunderson & Ronningstam, 2001; Hart & Hare, 1998) indicating a link between the two. However, Kellman and associates (1992) found that 29% of individuals meeting criteria for NPD also met criteria for ASPD, whereas only 2% of individuals met the criteria for ASPD alone. Watson and Sinha (1998) also found similar results among non-clinical samples (23% and 4% respectively). The significantly higher prevalence rates of comorbidity of NPD and ASPD, compared with ASPD as an isolated diagnosis, leads me to believe that the ASPD may in fact be a subgroup of NPD. Indeed, Gunderson and Ronningstam (2001) suggest that NPD is the 'white collar' version of ASPD, indicating external economic influence as being the difference between the two disorders. If ASPD is conceptualised as a subtype of NPD, then there would be much higher rates of narcissism in addiction, given the high prevalence of ASPD in individuals with SUDs. ASPD conceptualised as a form of NPD could also have significant implications for treatment for those individuals.

The *DSM-IV* (American Psychiatric Association, 2000) attempted to differentiate the two disorders by making the criteria for ASPD primarily behavioural and those for NPD primarily affective and interpersonal. Despite their descriptive differences, narcissistic and antisocial personality disorders share several core affective and interpersonal deficits such as a disregard for other people and neglect of personal obligations (Jackson, Livesley, & Schroeder, 1992), interpersonal exploitativeness, lack of empathy, envy (Holdwick et al., 1998) and grandiose fantasies of success and power (Gunderson & Ronningstam, 2001).

Depressive Symptomology

Individuals entering treatment for an alcohol use disorder often have high levels of depressive symptoms (Schuckit, 1995), with female substance users tending to have higher rates of comorbid depression and anxiety disorders than males (Blume, el-Guebaly, Taveres, & Zilberman, 2003). Among those meeting criteria for alcohol dependence, approximately 20% also met criteria for major depressive disorder (Grant, 2005), and about one-third of individuals with major depressive disorder also have symptoms consistent with a substance use disorder (Cassano et al., 2005).

Symptoms associated with major depression, dysthymia, social anxiety, and generalised anxiety disorder also overlap with features of covert narcissism (Caligor, Levy, & Yeomans, 2015; McWilliams, 2011). According to McWilliams (2011), the essential difference between the two groups is that narcissistically depressed people are subjectively empty, lacking a substantial self; whereas depressive people feel 'real' but inherently bad, and are subjectively full (of critical and angry internalisations).

With the overlap of covert narcissism and depressive symptoms, I expect that it could be easy to miss a diagnosis of NPD. Therefore, evaluating clients' sense of self and interpersonal functioning are especially important to ensure a more accurate diagnosis. This may also explain the lack of studies relating to covert narcissism, seeing as these individuals may instead be diagnosed as clinically depressed or with depressive personalities. As with the previously mentioned overlap with ASPD, this may also indicate that prevalence rates of narcissism and its comorbidity with SUDS are actually much higher than the literature suggests.

Conclusion

Studies have shown a high comorbidity of SUDs and antisocial and/or depressive personalities which also have differential diagnoses with NPD. It seems possible that the prominent features and behavioural expression of each of these personalities distract from an underlying narcissistic personality. The grandiose narcissist may be mistaken as an antisocial due to the illegal behaviours that are often associated substance use, while the depleted narcissist may be mistaken as depressive due to symptomology, such as depression and low affect, or self-harm and suicidality. Or perhaps in the case of comorbidity, the narcissistic personality may simply go unrecognised as the comorbid disorder again attracts focus with more pronounced symptomology. Additionally, chronic substance abuse itself may mimic or stimulate NPD – for example, an individual with a substance use disorder may become exploitative, self-focused, and lacking in empathy (often in conjunction with antisocial features). With this in mind, I am not surprised at the inconsistent range of prevalence rates of comorbid narcissistic personalities and substance use disorders, and I find it very concerning considering the impact that this 'misdiagnosis' may have on an individual's treatment and recovery.

PERSONALITY

In the *DSM-5* (American Psychiatric Association, 2013), each personality disorder is reflected in a unique profile with extreme scores in certain temperament scales. However, what all categories of personality disorders have in common is low self-directedness (Cloninger, Przybeck, & Svrakic, 1993). This is defined by poor impulse control or weak ego strength, and is described as being irresponsible, purposeless, immature, fragile, blaming, destructive, ineffective, unreliable, helpless, poorly integrated, and low in self-acceptance. Likewise, Kose (2003) and Cloninger (2000) found that most individuals with personality disorders have poor interpersonal functioning and are described as being intolerant, self-centred, hostile or disagreeable, critical, unhelpful, revengeful, and opportunistic. Given these descriptions of personality disorders in general, it comes as no surprise that an individual with a personality disorder may be more inclined to use substances in order to manage the emotional distress resulting from poor interpersonal functioning.

Approach and Inhibition Behaviours

Much of the material sourced for this literature review either used Grey's (1982) Reinforcement Sensitivity Theory as a means to understand and measure overt narcissism, or repeatedly referenced a few select studies that had. More importantly, this appeared to be the main tool used in studies exploring the relationship between narcissism and addiction (as opposed to narcissism and other factors).

Gray (1982) proposed a relationship between personality and sensitivity to reinforcement based on impulsivity, anxiety, approach motivation, and avoidance motivation. He identified two systems of underlying behaviour: the Behavioural Inhibition System (BIS) and the Behavioural Approach System (BAS). In broad terms, the BIS relates to fear and anxiety and the BAS relates to reward and goal-directed behaviour (Carver & White, 1994).

Hamilton, Sinha, and Potenza (2014) found that low levels of BIS and high levels of BAS are associated with addictive behaviours, and that, more specifically, 'fun-seeking' and 'drive' are associated with substance abuse (Franken & Muirs, 2006). A similar pattern of BAS has been found among narcissistic individuals, where increased levels of narcissism corresponded with increased approach behaviours and decreased inhibition

(Best & MacLaren, 2013) which was mediated by 'extraversion'. This means that the more narcissistic an individual is, the less inhibited they are, and the more likely they are to engage in addictive behaviours. Extraversion is an important aspect of this correlation, because to engage in approach behaviours (such as using substances), the individual must be willing to participate in social situations where they are available.

Collins and Depue (1999) suggest that the production of dopamine in the brain (which is associated with reward and pleasure) may explain the relationship between high BAS and substance use. They propose that individuals with high BAS levels are reward-seeking and may engage in behaviours that increase dopamine levels. Stenason and Vernon (2016) suggest that if narcissistic individuals are more extraverted, they may have more opportunities to engage in social settings where substance abuse is prevalent. This increased exposure may then lead to substance use, and more opportunity to experience the positive and reinforcing effects of using the substance. Additionally, Franken and Muris (2006) suggest that increased levels of BAS may be a consequence of drug use (rather than precursor) with intoxication itself lowering levels of inhibition and anxiety, rather than lowered inhibition and anxiety leading to drug use.

Several theories have proposed neurological, biological and social explanations for levels of BAS and its relationship to associated risky behaviours, giving rise to another 'chicken or egg' argument – whether extraversion leads to social situations where substances are more available, or substance use results in lowered inhibitions. However, I wonder if the opposing theories represent a difference in overt and covert narcissism. For example, the overt narcissist may be more extraverted and therefore exposed to social situations leading to substance use, whereas perhaps the covert narcissist seeks substance use to overcome their anxiety. Either way, it would seem that both instances would lead to increased risk-behaviours due to decreased inhibitions.

Sensation Seeking

The Sensation Seeking Scale (SSS) was developed by Zuckerman (1971), and designed to measure individual differences in optimal levels of stimulation and arousal. It included characteristics of boredom; a need for varied stimulation (such as travel, drug

use, or engaging in thrilling or dangerous activities); resistance to authority; and an inclination toward an indulgent, extraverted lifestyle (disinhibition).

Sensation seeking has been found to be one of the best predictors of drug use (Zuckerman, 1979). High sensation seekers tended to experiment with drugs at an earlier age, and reported higher levels of enjoyment in their use (Carrol, Vogel, & Zuckerman, 1982). Zuckerman (1971) found that the more narcissistic an individual is, the higher sensation seeking they tended to be, and concluded that sensation seeking may raise both norepinephrine and dopamine levels in the body, similar to the effects of using amphetamines. Narcissism in itself, then, may predispose substance use seeing as it is positively correlated with sensation-seeking, which is one of the best predictors of drug use. However, sensation seeking has not been identified as a specific characteristic of narcissism in any reference material sourced for this literature review. I wonder then, if sensation-seeking is a mediating factor in whether narcissistic individuals are prone to abuse substances. From this perspective, narcissistic individuals present on a sensation-seeking spectrum, with those at the high end of sensation-seeking more likely to enter into drug use. Alternatively, perhaps there is a relationship between sensation-seeking and extraversion, since extraversion itself has been found to be a mediating factor. This would suggest that covert narcissists would not be sensation-seekers, since they are also less extraverted.

Consistent with other studies, Zuckerman (1971) found that male participants scored significantly higher on sensation-seeking. This may be relative seeing as males have already been identified as more frequently narcissistic, and higher in levels of narcissism than females. However, it also possibly indicates that the males in this population seek varied and novel experiences more often than the female participants, that females may have different motives for using substances, or are at a different stage in their drug use.

Impulsivity, Disinhibition, and Risk

Within the literature, impulsivity and disinhibition are personality traits associated with sensation seeking that have been linked to higher risk for substance use problems (Pitkanen & Pulkkinen, 1994; Hopwood et al., 2011). Ball (2002) found disinhibition to be related to drug dependence severity, polydrug use, more recent use, younger age

of first use, family history of addiction, and poor treatment response. Disinhibitory traits are also related to depression and anxiety symptoms, severity of personality pathology, childhood abuse, suicidality, violence, and criminality. I speculate then, that individuals with stronger disinhibitory traits would be prone to significantly higher risk and complications (such as health), than those who are more inhibited or the general population.

Narcissism has also been associated with higher levels of impulsivity (Foster & Trimm, 2008), addictive behaviours (Campbell, Goodie, Lakey, & Rose, 2008), a tendency to dismiss possible future consequences of decisions, and a preference for more immediate rewards (Crysel, Crosier, & Webster, 2013). This may account for the risky behaviours narcissistic individuals engage in, seeking the immediate and tangible effects of increased dopamine levels rather than intangible future consequences. Additionally, individuals showing higher levels of entitlement and exploitativeness have been found to engage in more selfish (Bonacci, Bushman, Campbell, Exline, & Shelton, 2004) and unethical behaviours (Brown, Chowning, & Tamborski, 2012), indicating that these behaviours would be restricted to overt narcissism, seeing as these traits are not strongly associated with the covert subtype.

Conclusion

Narcissism predicts a number of characteristics including fun seeking, motivation, extraversion, sensation seeking, impulsivity and disinhibition, which are significantly associated with increased risk-taking behaviours including substance abuse. However, the literature which explored these relationships measured overt characteristics only and have not explicitly addressed how covert narcissism may be linked to substance use.

THE SELF-MEDICATION HYPOTHESIS

The self-medication hypothesis suggests that an individual uses substances for affect-regulation. This was one of the concepts present in the literature where the narcissism and addiction perspectives came together.

Poor affect regulation has shown to be a significant risk factor for substance use and relapse (Catapano, O'Malley, & Sinha, 1999). Since maintaining a sense of control over

emotions is an essential self-regulatory mechanism central to narcissism, I speculate that the use of substances would provide an immediate and attractive form of emotional self-regulation. Maumeister and Vohs, (2001) suggest that narcissistic individuals may use substances as a means to 'refuel' the grandiose self, re-establishing a sense of omnipotence and relieving (or avoiding) frustration when narcissistic needs are not met. Dodes (1995) proposes that this link is so strong that a sense of power is re-established simply by obtaining the substance, like the alcoholic who feels relief at the point of ordering a drink, before any intoxicating effects have occurred.

Albanese and Khantzian (2008) propose that individuals do not choose to become dependent on a particular substance, but those who are prone to addiction experiment with different drugs and are drawn to a particular type because it makes them feel better than the others. Specific substances may be chosen for specific psychological and pharmacological effects according to individual needs, the emotional state of the individual, or the emotion experienced as most painful (Khantzian, 1985). Individuals high in neuroticism/emotionality (such as borderline, dependent, avoidant, and obsessive-compulsive personality disorders) may be more attracted to the sedative effects of alcohol or opiates, whereas individuals high in impulsivity/disinhibition (such as antisocial and narcissistic personality disorders) may be more attracted to the stimulant effects of cocaine or ecstasy (Sher & Trull, 1994).

Individuals struggling with feelings of emptiness, boredom, and/or depression tend to be drawn to cocaine (Albanese & Khantzian, 2008) to increase self-esteem, mood, energy and productivity (Dodgen & Shea, 2000). Albanese and Khantzian's (2008) identify two types of cocaine abusers: 'low energy' individuals who often feel chronically bored, depressed and fatigued - much like the depleted narcissist; and 'high energy' individuals who crave excitement (sensation-seeking) - much like the grandiose narcissist. Since cocaine produces activity in areas of the brain associated with pleasure and reward (Carlson & McCown, 2004), which has already been shown to correlate with narcissistic individuals, it is no surprise that cocaine abuse is very common among this population (Baumeister & Vohs, 2001). Driven and expectant of constant external gratification, I imagine the narcissist like a toddler, impatient for the ice-block promised by "mum" on a hot day. Cocaine, like sugar in the iceblock, serves

to invigorate both the tired grumpy toddler, and the over-excited one who can't get enough! Cocaine intoxication may gratify the 'toddler' within, and soothe the tantrum that is brewing.

Although different from the stimulating effects of cocaine, the literature suggests that the sedative effects of alcohol are also enticing to the narcissist. Alcohol softens defences and alleviates anxiety, and violent outbursts are commonly seen or heard from alcoholics, whose previously suppressed anger is released when intoxicated (Khantzian & Mack, 1989). Isenhart and Silversmith (1996) suggest alcohol abusers are highly defensive, using repression and denial to inhibit uncomfortable emotions. This may explain the relationship of alcoholism to the narcissistic individual who suppresses a great deal of rage and represses their underlying shame.

When comparing alcoholics and individuals with other substance use disorders, several studies (Skodol, Oldham, & Gallaher, 1999; Aizpiri, De medina, & Echeburus, 2009) found a significantly higher rate of NPD in alcoholics with comorbid cocaine dependence than in alcoholics only. This may be representative of the narcissist's conflicting internal experience and the struggle to regulate affective states. For example, they may be drawn to substance use to regain a sense of omnipotence when feeling powerless, drawn to cocaine to receive the stimulating and rewarding effects, and drawn to alcohol to help relieve (and release) unconscious rage. This may also reflect the severity of emotional instability, where an individual would normally be drawn to a single class of substances (such as sedatives OR stimulants), the narcissist is drawn to both ends of the spectrum.

Conclusion

The literature suggests that the abuse of specific substances is dependent on particular personalities. Cocaine is especially rewarding to individuals who have difficulty regulating affect, particularly feelings of emptiness, boredom, or depressive states; which is consistent with characteristics of a narcissistic personality. Alcohol also appeals to the narcissistic individual, releasing anxiety and the tension created in suppressing feelings of rage. The findings suggest a potentially important link between sensation-seeking and a preference for cocaine. As alcohol is legal, personality traits

related to criminal behaviour may be more likely to predispose other drug addictions (Hopwood et al., 2011).

SURRENDER IN ALCOHOLICS ANONYMOUS

Another significant theme which emerged in the literature was the relationship between narcissism and surrender in Alcoholics Anonymous (AA). This is significant because AA is the most common and recognised 12-step recovery programme (Amato, Davoli, & Ferri, 2006). Narcotics Anonymous (NA) is based on the same concepts but targeted at other substance users (Narcotics Anonymous, 2015). Given their popularity and affordability (volunteer-run), the effectiveness of the AA and NA with narcissistic addicts is especially relevant to this research project.

Tiebout (1961) observed a change process in AA participants which he named "conversion", beginning when alcoholics 'hit rock-bottom', and must no longer 'fight life' but surrender to it. He described this act of surrender as a moment when an individual's unconscious defiance and grandiosity no longer function effectively, and they begin to 'accept life'. Tiebout states that as conversion progresses, the alcoholic must become more mature and humble to avoid returning to the belief that they can control their drinking. Along with surrender, he believes that if alcoholics truly accept the presence of a power greater than themselves, they may begin to modify their 'deepest inner structures'. Indeed, AA (2001) supports this idea, describing alcoholism as "an illness which only a spiritual experience will conquer" (p.44). These ideas stress the absolute necessity of surrender and spirituality in the treatment of alcoholism in AA's 12-step programme.

Collectively, the first three steps of AA's 12 Step programme involve the basis for Tiebout's (1961) notion of conversion - particularly surrender. Step One is admitting powerlessness over alcohol, Step Two is believing that a 'Higher Power' can restore sanity, and Step Three is making the decision to turn one's own will and life over to 'God'. While the programme may be effective for many, not everyone is able or willing to internalise and implement AA's first three steps. Hart and Huggett (2005) acknowledge that little is known about factors that may influence the degree to which alcoholics in early stage recovery have the capacity or motivation to accept the first three steps of AA, though they suggest that personality may have some influence.

Specifically, several studies (Mack, 1981: Fox, 1987; Brown, 1992) suggest that false pride and narcissism are core issues for alcoholics in recovery.

The literature suggests that acceptance and surrender to the first three steps of AA have a negative relationship with narcissism – that is, increased narcissism results in decreased surrender. For example, in three separate studies, high narcissism scores in exploitativeness, exhibitionism and sense of entitlement, related to low levels of acceptance of AA's 12 steps; and low narcissism scores related to higher levels of acceptance (Allen, Barry, Fenzel, & Reinert, 1993; Allen, Estadt, Fenzel, Gilroy, & Reinert, , 1995; Reinert, 1997). Hart and Huggett (2005) examined the relationship between levels of narcissism and acceptance of steps 1-3. While evidence suggested that highly narcissistic alcoholics tend to be significantly more rejecting of steps two and three, they found that participants who scored high on narcissism did not tend to differ from participants who scored low on narcissism in step one. These results indicate that while narcissistic alcoholics appear to acknowledge their powerlessness and lack of control over alcohol use, they struggle to accept AA's "God Steps" as a solution to their drinking problem. The narcissist may be open to acknowledging they are not all-powerful, but are perhaps unable or unwilling to give their power over to another. Given the narcissist's tendency to use substances to self-medicate overwhelming feelings, it is possible that working AA's 12-step programme may actually increase anxiety creating a higher and more immediate risk of relapse.

Almost all the literature sourced for this dissertation referencing 12-step programmes focused on AA. However, Trimpey (1990) introduced the Rational Recovery (RR) programme which differs from AA in that it does not advocate a need for surrender, and instead aims to empower individuals to take control of their addictive behaviour rather than relying on a Higher Power. This programme may therefore be more suitable for narcissistic alcoholic clients.

Conclusion

The literature suggests that narcissistic individuals may be more prone to accepting Step One, but not Step Two or Three of the 12-step programme. I was surprised by this result, because as discussed above, narcissistic individuals spend a great deal of energy on maintaining a sense of omnipotence and I therefore expected that

acknowledging a sense of powerlessness would be especially difficult for the narcissist. I wonder about the specifics of Step Two and Step Three, whether the narcissist's inflated pride and unrealistic estimation of capabilities leads to resistance in accepting that they need help to control their alcohol use, if it is the struggle to accept the idea of a 'Higher Power' (religiosity), or both. I am strongly reminded of my father in this instance as he maintained a very openly expressed anti-religious stance where all forms of spirituality were rejected and devalued. Acknowledging alcoholism in the first instance would be significant, let alone considering the possibility of a 12-step programme. Trimpey (1990) offers one possible alternative to the AA paradigm, however the Rational Recovery programme only operates in four countries of which New Zealand is not one.

A STUDY ON COVERT NARCISSISM IN ADDICTION

While there was abundant research on overt narcissism in addiction, very little referenced covert narcissism. I have therefore included the one study I was able to source. Although it does not signal a main theme in the literature, it is still significant in the purposes of this research project.

Karakoula and Trilvia (2016) conducted a study on the presence of overt and covert narcissism in substance-dependent individuals in treatment, compared with individuals from the general population. They found significant differences between addicted and non-addicted individuals, particularly in relation to covert narcissism. This was relevant to four specific subscales of the Narcissistic Personality Inventory (NPI), including 'hiding the self', 'devaluing', 'contingent self-esteem', and 'entitlement rage'. These differences indicate that covert narcissistic addicts tend to hide their needs and vulnerabilities from others, and devalue both themselves and others when expectations are not met. Their sense of self-esteem is dependent on external validation, and when needs for entitlement are not met, they may become full of rage. These findings highlight a basic deficit in the self, expressed in an inability to self-regulate affect, self-esteem and underlying shame.

Interestingly, this study showed no significant differences in rates of overt narcissism between addicted and non-addicted samples. This finding was unexpected, given that much of the literature suggested that NPD and substance use disorder are related (for

example, Ronningstam, 1998; Gunderson & Ronningstam, 1990; Vaglum, 1999, Chou et al., 2008;).

Although both overt and covert subtypes of narcissism were present in Karakoula and Trilvia's (2016) study, the covert subtype was overrepresented. This may be because those with covert narcissistic personalities are more likely to seek and commit to treatment than overt subtypes (Ansell et al., 2009), and indeed, the sample was comprised of individuals who had sought help, committed to treatment, and had almost completed the programme. It may be possible that addicted individuals who don't seek help or who drop out early in the programme, are characterised by more grandiose narcissistic traits, as represented in NPD or antisocial personality disorder.

Limitations of the Study

Participants were invited to volunteer for the research so it is therefore possible that certain characteristics (such as openness with self-disclosure) may have affected sampling. Gender differences were noticeable in the study, including an overrepresentation of men in the substance-addicted sample, and an overrepresentation of women in the control group. Therefore significant gender-based comparisons were not possible. Additionally, assessing differences in drug of choice and participants' progress over time (such as before, during and after treatment) could have increased understanding of how subtypes of narcissism manifest across the course of addiction and treatment.

Conclusion

This study found that covert narcissism and addiction were related, and that, contrary to the majority of literature sourced for this dissertation, overt narcissism and addiction were not related. However, this study is different to other research in that both subtypes of narcissism were measured, with covert rather than overt narcissism was overrepresented in the sample. It is no surprise then, that the results may vary. However, the difference found between addicted and non-addicted groups (ie, presence of self-esteem dependent on external validation, inability to self-regulate affect; feelings of entitlement, shame and rage) is consistent with wider literature on narcissism, which is predominantly based on the overt subtype. This indicates that while both subtypes may be expressed differently, they share the same core issues.

These findings further support covert narcissism as a valid and relevant subtype which is so evidently lacking in current literature, reiterating the need for further research in the subject area.

LIMITATIONS OF THE AVAILABLE RESEARCH

The literature sourced for the purposes of this dissertation offers important information pertaining to the relationship between narcissism and addiction. However, there are several limitations which impact on the findings of this study.

Research on NPD is based on a very specific and narrow definition of narcissism. All studies except the one described above (Karakoula & Trivlia, 2016) assess pathological narcissism as defined by the *DSM*. Limiting research to include only the grandiose or overt subtype, represents a restricted view of the spectrum of a narcissistic personality. Diagnosis based on a set number of objective criteria can miss more subtle presentations of the personality that do not necessarily meet a full diagnosis; and ignore significant core beliefs, attitudes and origins. The *PDM*, however, takes into consideration the subjective, subtle distress of personality pathology, and complements the *DSM* by placing more emphasis on subjective internal, emotional, and cognitive experiences (Albanese & Khantzian, 2008). The combination of the two approaches can best make sense of the relationship between psychological distress contributing to the development of narcissism, and the development and maintenance of SUDs.

Self-report inventories were the predominant tool for measuring narcissism, which relies on honest evaluations of the self for accurate assessment. Narcissistic individuals however, have unrealistic views of the self and may therefore answer in a manner that reflects more positively. Other assessment tools (for example, the Narcissistic Personality Inventory, the Minnesota Multiphasic Personality Inventory and the Millon Clinical Multiaxial Inventory) primarily assess NPD according to a *DSM* diagnosis rather than aspects of pathological narcissism. Some items also overlap multiple different personality disorders (Blais, Handler, & Hilsenroth, 1996), and therefore prevent the differential diagnosis of pathological narcissism from other personality disorders.

Additionally, studies focusing on the assessment of specific narcissistic traits are based on the assumption that narcissism can be reduced to certain traits that characterise both clinical and nonclinical populations. However, Kernberg (1975) suggests that normal and pathological narcissism are two independent dimensions and their differences are qualitative, for example, variations in personality pathology and dynamic processes, and how these are expressed.

To conduct more useful research, pathological narcissism needs to be conceptualised in a more comprehensive manner than as defined by the DSM because there are varying aspects of narcissism which are present on a continuum of pathology (such as overt/covert and healthy/pathological) (Kernberg, 1975). In addition, it is important to develop more comprehensive understandings of the relationship between pathological narcissism and addiction, and the specific narcissistic disturbances that underlie this relationship.

A note on the interpersonal

Although previous personal research (ie, thematic analysis) and a brief current search found some literature discussing interpersonal factors relating to narcissism and interpersonal factors relating to addiction, I was unable to source any literature pertaining to the specific combination of both. By this, I mean any text relating to one's experience of being in relationship with a substance-dependent narcissist, and particularly how this may differ to being in relationship with the narcissist without addiction. Given the relationship between addiction and narcissism, the problematic nature of forming and maintaining relationships (or a therapeutic alliance) with narcissistic individuals, and the increased risk to mental and physical health of a narcissistic client in addiction, I believe this to be an area of paramount importance for any clinician working with narcissistic personalities and/or addicted individuals with strong narcissistic characteristics. A large proportion of research on the relationships between narcissism and addiction have been quantitative studies, leaving a significant gap in the more personal and relational aspects of working with this client group. Given that there may in fact be a significant number of narcissistic clients in addiction who may be overlooked due to differential diagnosis, increased awareness and understanding could improve long-term outcomes for these individuals.

A note on my experience

While I have worked with several narcissistic clients at the addiction clinic where I am based, each has presented with variations of the overt personality. For example, male clients tended to be more consistently grandiose, with those at young-adult age seemingly more relational and 'charming', and those of the middle-older age group appearing more authoritative and devaluing of others. The one female client presented inconsistently, vacillating between defiance/devaluation and decompensation/idealisation. I speculate that this presentation may be why female clients with a narcissistic personality may frequently be diagnosed as borderline (Berg, 1990). Interestingly, I found younger male clients eliciting positive countertransference responses, and the middle-older age group, both male and female, eliciting negative countertransference responses. I wondered if this was partially a transference response, given that I maintain a close relationship with my brother who appears to be a high-functioning narcissistic extension.

Coincidentally during this research project, I met with a new client whose presentation was very similar to my father – of similar age, narcissistic presentation, and alcoholic. As previously mentioned in the method section, I began to feel saturated and suffocated by the process. I was attempting to maintain my own relationship with my father, working with a man who closely resembled him, as well as reading, writing and reflecting for the purposes of this dissertation. I was overwhelmed by the content and the experience, and noticed my resistance and avoidance to engage on all levels of the study, the work, and the relationship. I began to wonder about how these processes paralleled, how this may impact on my capacity to work effectively with the client, and the kind of support system I would need to put in place in order for this to happen. I found personal therapy very effective in helping to deal with overwhelming emotions, and to process my feelings of rage, incompetency, and shame; and supervision especially helpful to separate my transference and countertransference. I noticed that I was constantly expecting to be devalued by the client, had expectations on myself to be a 'perfect' therapist, knowing that I would inevitably 'fail', and felt that my experience with this one client would somehow define my capabilities as a clinician. My experiences were both consistent with countertransference responses to the narcissistic client (Glickauf-Hughes & Schultz, 1995), the addicted client (Adams &

Shinebourne, 2007), and with my relationship with my father. However, given the range of countertransference responses reported when working with both client populations, I am further inclined to reiterate the need for more studies on this aspect of the relationship.

Similar to the difficulty working with my recent narcissistic alcoholic client, I experienced a 'block' in writing this dissertation. It was another parallel where I noticed similar expectations of perfection, and an expectation of inevitable failure. Of course, like client supervision, dissertation supervision was especially helpful in working with and processing these issues.

CHAPTER SUMMARY

This chapter is a review of the literature, presented in themes and subthemes. This included a discussion on whether narcissism precedes addiction or addiction precedes narcissism; co-occurrence of narcissism and addiction, differential diagnoses, common personality factors, the self-medication hypothesis, the relationship between surrender and narcissism in Alcoholics Anonymous, and a study on covert narcissism. Additionally, I discuss limitations of the available literature, and contribute to the subject area using my personal experience of working with narcissistic addicts.

The following chapter presents a summary of the findings in the form of a brief discussion, examines implications for treatment, reports on the limitations of this study, and suggests areas for further research.

CHAPTER SIX: DISCUSSION

Most of the literature sourced for this research project suggests that personality predisposes addiction, or at the very least increases the risk of substance use and 'abuse. The research question first sought to investigate if there was a relationship between narcissism and addiction, of which a positive relationship was identified. However, it is extremely difficult to separate substance-induced behaviours from persistent behaviour patterns, particularly among individuals with chronic substance abuse histories (van den Brink & Verheul, 2005). This causes increased difficulty in determining whether personality pathology or substance addiction is the cause or symptom. Additionally, it is also possible to overlook a narcissistic personality due to more overt expressions or overlapping symptoms associated with other disorders as discussed above. This is particularly relevant to those with comorbid disorders. Together, this stresses the importance of assessing clients beyond obvious symptomology, and thoroughly investigating underlying motivations, attitudes, and emotional experience.

Research on specific characteristics of narcissism and individuals with substance use disorders revealed several corresponding personality traits. High levels of fun-seeking, sensation seeking, drive, impulsivity, and disinhibition, are all significantly associated with increased levels of dopamine in the body, and an increase in risk behaviours. Individuals with these traits tend to feel less anxious, and focus on short-term rewards at the expense of longer-term goals, and are not concerned with minimising negative consequences. Together, these traits are consistent with overt narcissism, which is shown to be a risk-positive personality style. Given that the ability to delay gratification (self-control) is associated with a number of benefits, it is likely that the tendency toward immediate gratification leads to a number of self-defeating behaviours that hinder long-term success. While narcissistic individuals may engage in a range of risky behaviour, they are particularly drawn to substance use, and more specifically, to the instant and intense effects of stimulants such as cocaine. The relieving effects of alcohol also appeal to the narcissistic individual who typically suppresses feelings of rage, as the disinhibiting effects allow its release. Drug of choice is representative of a wider issue however, which is the use of substances to self-

medicate, regulate emotions and re-establish a sense of omnipotence. It can be expected then, that an individual with pathological narcissism is more likely to use substances and is at greater risk of developing a substance use disorder.

Alcoholics Anonymous propose that lack of humility plays a foundational role in the onset of alcoholism, and that the transformation of such narcissistic traits is essential to recovery. Admitting powerlessness and surrendering to a 'Higher Power' are principles in the first three steps of AA's 12-step programme which serves to begin addressing these narcissistic traits. However, research suggests due to fundamental characteristics of the overt narcissistic personality (e.g. inflated pride, overestimation of capabilities), these individuals tend to be highly resistant to 'surrender'. This creates a paradox – that while AA addresses the treatment of narcissism, for the narcissist it may be an unworkable programme. Alternative programmes, such as Relational Recovery, may therefore be better suited to the addicted narcissist.

While not always explicit in the available literature, there are two presentations of narcissism; overt (grandiose) narcissism and covert (vulnerable) narcissism. Overt narcissism is assessed using the Narcissistic Personality Inventory and is associated with feeling entitled and superior to others; whereas covert narcissism is assessed using the Hypersensitive Narcissism Scale and is associated with feeling inadequate and incompetent. Similarly, overt narcissism is positively related to self-esteem while covert narcissism is negatively related. Not surprisingly, overt and covert narcissism are weakly correlated. An important issue, then, is determining which factors are shared and which factors differentiate the subtypes. My research has shown that the two share a need for external validation to regulate self-esteem, devaluation of others, inability to self-regulate affect, and feelings of entitlement, rage and shame. General literature on narcissism differentiates overt and covert narcissism by their presentation, with characteristics such as inhibition, distress, depression, and insecurity relating to the covert subtype (Caligor, Levy, & Yeomans, 2015); and confidence, arrogance, and exploitativeness relating to the overt subtype (Ansell, Cain, & Pinkus, 2008).

The literature consistently showed higher levels of narcissism in men than women, and that men were consistently more frequently diagnosed with NPD. Substance abuse and dependence may reflect attempts on the part of men with NPD to self-medicate to

maintain a sense of omnipotence and grandiosity, to protect a very fragile self-esteem and to manage intolerable affect. This suggests differences in how women and men resolve issues related to self-esteem and shame; and suggests that differential gender-related approaches to treatment may be justified.

Implications for Treatment

Individuals with NPD constitute some of the highest-functioning clients in outpatient settings and also some of the most impaired and unmanageable among patients in inpatient settings (Caligor, Levy, & Yeomans, 2015). According to Kernberg (1975), of all the personality disorders, NPD spans the broadest spectrum of severity. As a result, it is useful to distinguish not only between overt and covert presentations, but also among other specific facets of the disorder. In general, as severity of narcissistic pathology increases, aggression and deficits in moral functioning become more evident, and interpersonal functioning deteriorates (Kernberg, 2007). This causes significant challenges when working within this client population. Given that both addiction and personality pathology have been linked to growing up in a dysfunctional (often substance-dependent) family, it is no surprise that rates of dually diagnosed substance abuse are increasing alongside increased rates of addiction, divorce, unemployment, violence, and crime (Brown, 1993).

Ekleberry (2009) maintains that individuals with comorbid personality and substance use disorders seek a way to escape from the reality of life, and dread the loss of their illusions. She therefore suggests addressing what clients are trying to deny, minimise and hide. Addicted clients tend not to disclose the full extent of their using, and narcissistic clients tend not to acknowledge the extent of their dysfunction. Additionally, narcissistic individuals believe they are special and unique, which creates resistance to acknowledging that they have become dependent on substances. It also leads to the belief that they are immune to the negative effects of using substances and that they can quit at any time (Beck, Freeman, & Davis, 2004). These defences can cause significant difficulties in engaging these individuals in treatment. In fact, because the narcissist thinks so highly of their capabilities, it is likely that they will not engage in therapy at all, unless for a secondary issue such as depression, anxiety, or marital difficulties.

For individuals with NPD, validating their thinking and emotional experience is critical for the development and growth of more adaptive skills (Izenberg & Rodin, 1997). However, while empathy and non-judgmental acceptance are core components of psychotherapy, specific dynamics presented in addicted individuals also require the use of confronting and challenging interventions by the therapist (Fischer, 2012). The effective skill is in maintaining an empathic, non-judgmental stance while disagreeing with the client's self-harming behaviours. Because the narcissist avoids experiences of shame and responsibility, they typically project blame on to others for their difficulties, independent from their own behaviour. Given their sensitivity to the difficulties of reality (and thus wanting to escape by using substances), confronting the narcissistic client with feelings that they have essentially been self-medicating from is not an easy task. Beck, Davis and Freeman (2009) reflect that the narcissistic individual does not tolerate discomfort well, and is sensitive to discrepancies between fantasies and reality. It is therefore necessary to join with these individuals in an empathic and sustaining manner if there is any hope of forming a therapeutic alliance. The flip side to this, however, is that empathy may be all the narcissistic client is seeking, and once gratified, they may be compelled to end treatment. Connecting with this client population and retaining them in treatment is thus an obvious challenge.

As an alternative to individual therapy, narcissistic individuals may also be suited to therapeutic community models. Kernberg (1982) suggested that those with narcissistic personalities would tend to stay longer in therapeutic communities because this treatment model may actually gratify their narcissistic needs. A study by Ravndal and Vaglum (1991) supported this concept, as they found narcissistic scores increased significantly over the course of treatment. However, since most personality disorders appear to best respond to individualised treatment (Brown, 1989), facilities may need to employ additional therapists to provide such care. Although therapeutic community models promote abstinence and recovery, these results do not suggest that narcissism itself is addressed.

Rather than conceptualising addiction as simply a chemical dependency, the majority of literature recognises the combination of biological, psychological, and social factors; as well as personal needs and character traits (including normal and pathological narcissism). This combination predisposes individuals to seek relief in a particular

substance to self-medicate. Determining the personality characteristics of individuals who choose a particular drug will be beneficial in implementing treatment plans and prevention for individuals at risk of abusing a particular type of substance – such as anger management for the alcoholic (or pre-alcoholic). When the individual is taught about problematic character traits and defences, they can learn to manage or replace them with alternative, healthier ways of coping. Understanding differences in personality structure and function will help to determine more effective treatment plans, enhance retention in treatment programmes, generate more positive treatment outcomes, and reduce rates of relapse.

Psychodynamic studies imply that many addicts have disturbances in the development and function of the self. Why some narcissistic individuals abuse substances and others don't is a question which needs further exploration. Experiences from psychotherapy indicate that for many addicts, the narcissistic disturbances come first (Wurmser, 1974). On the other hand, for some addicts, use of substances may weaken defences and increase narcissism. Regardless of whether addiction is primary or secondary to narcissistic disturbance, psychodynamic understandings have important implications for the treatment of substance dependent individuals (Vaglum, 1999). As such, Dodes (1988) proposes combining 12-step programmes with psychotherapy, since they provide a "dual level of therapeutic approach, with a splitting of the narcissistic transference between the therapist and AA" (p. 283). He believes this dual approach is particularly useful since the inevitable frustration and disappointments encountered in individual psychotherapy may result in increased vulnerability to relapse. However, AA is available day and night and can therefore provide consistent support and 'selfobject' experiences, specifically in the areas of affect regulation and twinship, during these crises (Robinson, 1996).

Techniques such as the 12-steps may prove more effective in treating particular narcissistic characteristics, as they place emphasis on exploring 'character defects' rather than on behaviour modification. The altruistic and supportive nature of the 12-step fellowship can often help to effectively address narcissism alongside the addiction (Gersabeck, 2006). From a self-psychology perspective (Kohut, 1971), twinship can be experienced through the sense of belonging and of finding peers with similar experiences, and mirroring in the acceptance and attention received from other

members. Sponsors build self-esteem by serving as role models, and sponsees build self-worth by knowing that they are fully accepted by their sponsors (Robinson, 1996).

Given that narcissistic individuals may struggle with 'surrender' (which is crucial to working the 12-steps) and remaining engaged in AA (or NA) meetings, it may be useful for clinicians to take emphasis off the concept of a 'Higher Power' and instead place it on the importance of using more tangible forms of help, such as other members in the fellowship. At least in the short run, this strategy may help to prevent premature disengagement from psychotherapy or recovery treatment. For clinicians who want to support the client's integration into the spiritual side of AA, therapy with narcissistic clients might also address the issue of humility and how grandiosity interferes with the process of personal development and addiction recovery. Clarifying misunderstandings may help remove barriers to spiritual growth (Hart & Huggett, 2005).

Increased knowledge of the relationship between narcissism and addiction might help to better address the role that substances have played in managing affect regulation. This will hopefully assist in reducing rates of relapse by helping clients become more aware of the unconscious dynamics that predispose them to substance use. This may also encourage the development and application of more targeted interventions and treatments.

Limitations of this Dissertation

Given that hermeneutic research is highly subjective, it is not replicable or empirical. Any researcher attempting to replicate this study would inevitably come to very different conclusions given that their individual subjective experiences, responses and reflections would impact on the study in a unique way. That being said, it does not discount what this particular dissertation contributes to psychotherapy, addictions, or other relevant fields. Additionally, as previously discussed, I was only able to source limited data on covert narcissism. Most research is based on overt forms of narcissism and is therefore not representative of the entire narcissistic population. While I have included aspects of covert narcissism wherever I could, this inevitably impacts my findings. Finally, this study did not incorporate interpersonal factors related to the client population such as transference, countertransference, or the therapeutic

alliance. While there was no available literature on this specific facet of the addicted narcissist, it may have been possible to explore each perspective individually and bring them together to compare, finding similarities and differences. The presence of covert narcissism in addiction, and interpersonal dimensions related to the treatment of the addicted narcissist are therefore obvious areas for future research.

CHAPTER SUMMARY

In this chapter, I summarise and discuss the findings from this research study, and their implications and recommendations for treatment with the client population. Additionally, I close this dissertation with a conclusion and final words.

CONCLUSION

This research project was motivated by personal experiences with my father and with the client population. My initial aim was to explore the presence of addiction in relation to a narcissistic personality, with implications for treatment. I believe that this investigation has successfully identified connections between the two subject areas, as well as areas which need further exploration and research.

I found that much of the literature suggested that personality pathology was a precursor for addiction, and that addiction itself was implied to stem from narcissistic disturbance in early childhood. In later life, substances are used to manage feelings of powerlessness, shame and rage; with drug of choice being relative to the emotion deemed most intolerable. I was able to identify specific characteristics which leave the narcissist vulnerable to substance use and other risky behaviours, which could have significant implications for mental, emotional, and physical health. The connections made between narcissism and addiction also highlight important implications for treatment. The literature suggests that the narcissistic addicted client is highly defended, interpersonally dysfunctional, likely to leave treatment prematurely, and vulnerable to relapse. Given the high rates of comorbidity with Narcissistic Personality Disorder and Substance Use Disorders, and the difficulty these individuals have engaging in treatment, increasing understanding and awareness, and improving treatment plans is essential to successful treatment. It is paramount to distinguish between severity and forms of narcissistic pathology, confront defences empathically,

encourage engagement and retention in therapy and recovery, and to combine both therapeutic and addiction treatment.

Not only do these results indicate significant connections between narcissism and addiction, they also highlight significant gaps in the literature. Research pertaining to covert narcissism and interpersonal factors in the addicted narcissist were absent from the literature. This was because the existing research is based on the *DSM* definition of narcissism.

Narcissists are dependent by nature, depending on others to feed their inflated self-views. They crave affirmation from others like a physical addiction. It is not surprising then, that narcissistic individuals are vulnerable to other dependencies, such as drug addiction (Goodman & Leff, 2012). The narcissist, like the addict, gets pleasure from behaviours and actions that feed their narcissistic supply. When that falls short, they seek a similar high from other sources, such as alcohol and drugs. Furthermore, narcissism, like addiction, serves as a regression into a grandiose self. However, after repeatedly using substances to re-establish feelings of power and control, they may be eventually forced to admit that they are powerless to their addiction. In essence, their experiences embody the paradoxes at the centre of both narcissism and addiction (Fischer, 2012).

From the findings of this research, I propose narcissism as an addiction to esteem, and addiction as a narcissistic pursuit.

Final Words

Engaging in this research has helped to broaden, deepen, and develop my understandings of narcissistic individuals in substance addiction. Although my interest was in a specific and defined sub-population, I believe that the findings of this study can be applied more broadly across the fields of psychotherapy and addictions. Not only has the process of engaging in the research helped to develop my capacity as a psychotherapist working with this client population, it has also helped to develop my empathy towards my father as I make sense of who he is, and of our relationship. My hope is that through this dissertation, I can offer other clinicians and children of narcissistic and/or addicted parents a similar opportunity.

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