

- [Events](#)
- [Locations](#)
- [News](#)
- [Resources/Articles](#)

Search...

## [Remuda Ranch](#)

### **For new patients and clinical professionals**

Admissions 866.390.5100

Other Inquiries 800.445.1900

#### Menu

- [About](#)
- [Conditions We Treat](#)
- [Admissions](#)
- [For Health Professionals](#)
- [For Families](#)
- [For Alumni](#)
- [Contact](#)

# Volume 7, Issue 1 - Narcissism and Eating Disorders

[Home](#) > [Resources/Articles](#) > [Remuda Review Articles](#) > Volume 7, Issue 1 - Narcissism and Eating Disorders

Volume 7, Issue 1

Narcissism and Eating Disorders

Case Study: Narcissism and Bulimia Nervosa

With the current issue of The Remuda Review, we continue our series of articles on common co-occurring problems faced by eating disorder patients. Throughout this series, we are considering the assessment, conceptualization, and treatment of self injurious behavior, anxiety disorders, mood disorders, substance use, trauma, personality disorders, and other co-occurring issues within Remuda's bio-psycho-social-spiritual model. In each article, we consider how these co-occurring issues relate to eating disorder development, symptoms, and maintenance, and, where relevant, variable manifestations based on age,

development, and culture.

The present issue focuses in depth on our ninth topic: narcissism and eating disorders. In our experience, a surprisingly large percentage of patients with eating disorders have narcissistic issues. Yet full-blown narcissistic personality disorder is rarely diagnosed in those with eating disorders. This may lead to a lack of clinician awareness of the subtler forms of narcissistic wounding in eating disorder patients. Such wounding greatly complicates eating disorder treatment, and, if not recognized, will often lead to power struggles with patients and premature termination of treatment. As such, there is a clear need to understand the co-occurrence of narcissistic wounding and eating disorders, and methods for addressing this complex situation. Toward this end, we hope the article and case study in this issue of *The Remuda Review* will serve as a short primer on best practices for understanding, assessing, and treating this co-occurrence.

## Narcissism and Eating Disorders

A. David Wall, PhD

Remuda Ranch Programs for Eating Disorders

“He heals the brokenhearted and binds up their wounds.” (Psalm 147:3)

Narcissistic wounds often contribute to the development and maintenance of eating disorders (EDs). This article defines narcissistic wounds, how they arise and affect behavior, how they relate to EDs, and how professionals can help individuals so wounded to heal.

Based on meta-analysis (Cassin & Ranson, 2005), narcissistic personality disorder (NPD) is diagnosed in somewhere between 2% and 16% of ED patients, with the lower estimate of 2% arising from the more reliable assessment procedures. Even among Remuda’s inpatients being treated at the intensive inpatient level, only 2% of adult patients are diagnosed with NPD traits. Nevertheless, on psychometrically reliable and valid measures of narcissistic beliefs, ED patients score significantly higher than non-clinical controls (Sines, Waller, Meyer, & Wigley, 2008). Research suggests that bulimic attitudes are associated with classic NPD traits (Brunton, Lacey, and Waller, 2005), and that restrictive eating is associated with the “poor me” form of narcissism in which others are viewed as abusive and the individual must, like a martyr, place others’ needs first (Brunton, Lacey, and Waller, 2005). As such, there is evidence that narcissistic wounding—a broader concept than NPD—is indeed related to ED development and maintenance. Below we explore the concept of narcissistic wounding in relation to EDs.

Freud derived the term, narcissism, from the classical myth of Narcissus and Echo. Narcissus was cursed to experience an unfulfillable love. As such, Narcissus fell in love, not so much with himself, but with his image. Stooping over a clear fountain, he saw his reflection in the water. He did not recognize the image as his own. He desired the person he saw, but each time he touched the image, the water stirred and the image disappeared, reappearing only as the water settled. Possessed by desire, Narcissus could not pull away, even when he discovered the image was his own. He would not leave the stream to eat, nor disturb his image to drink, so he died from hunger and thirst.

Echo saw Narcissus by the fountain and fell in love with him. But a goddess had punished Echo by taking away her voice, allowing her only to echo others’ voices, so Echo silently watched Narcissus’ plight. Brokenhearted by his death, she stopped eating until her body vanished. All that remained was her echo-bound voice, repeating others’ words.

This myth describes more than a self-centered young man and the woman who loved him. First, it astutely

portrays the plight of those absorbed by self-image. ED patients can be as focused on their image as Narcissus. Sometimes their self-obsession appears vain, but most of the time they are obsessed with perceived flaws in their image, feeling disgusted and ashamed. These feelings may be hidden or openly expressed. In either case, the obsession with one's image fails to deliver the love and validation which the person craves. The myth also portrays the plight of those obsessed with another. Like Echo, many ED patients have difficulty speaking their thoughts and feelings. They choose to sacrifice their own values and beliefs, indeed their own voice; to gain acceptance, they echo their peers, parents, or partner, hoping that this other person will fulfill their overwhelming needs for love and validation. But in the end their strategy does not work, as they lose their identities and never obtain the validation they had hoped for.

Narcissus and Echo may have been narcissistically wounded. Narcissus compensated through grandiosity and arrogance—classical narcissistic personality disorder (NPD). Echo's compensation involved status by proxy. Echo believed that obtaining Narcissus' love and acceptance, especially given how cruelly he was known to reject others, would provide her with status. She would be the only one good enough to win his heart. But, alas, it was not to be.

### Development and Maintenance of Narcissistic Wounds

Kohut (Daniels, 2007) suggested that parents are mirrors from which children form their self-image. Most parents recall times their children performed for them, intently looking into the parents' faces for a response. Children gain validation as parents reflect back acceptance, joy, and delight. Through this experience, children attach to their parents and grow beyond narcissistic approaches to the world. They develop healthy identities. Without healthy mirroring, children's sense of self remains fragile, distorted, and self-focused.

Narcissistic wounds arise from repeated experiences of invalidation, such as rejection, neglect, conditional forms of love, and/or abuse. Central to narcissistic wounds is the spoken and/or unspoken message reflected back to the individual, "Who you are is not acceptable."

When grooming in the morning, most of us look in the mirror. Once we adequately groom, the mirror tells us we look okay. So we stop grooming and move on with our day. However, if the mirror tells us we look unacceptable, we may feel compelled to fix what is undesirable. If the mirror continues to reflect back an objectionable image, we may hide our unacceptable feature(s) to avoid social rejection or embarrassment. We continue to work on our defects, trying to make them pleasing. The only way we can know if we have become satisfactory is to look in a mirror at our reflection.

In the same way narcissistically wounded people become obsessed with their image and try to get the mirrors—other people—to say they are okay. Some avoid mirrors—people—and rage at their own perceived ugliness and/or the failure of the mirrors to reflect back an acceptable image.

Developmental theorists recognize that children pass through a self-centered stage marked by grandiosity and omnipotent fantasies. Often extremely demanding, children in this stage have little frustration tolerance or ability to delay gratification. Freud termed this stage, primary narcissism, and believed it developmentally necessary and beneficial. The omnipotent fantasies gradually dissolve as children realize they do not have control and must depend on adults. In resolving the fantasies, children's emotional attachment switches from self (narcissistic) to parents (anaclitic). But if resolution does not occur, children remain emotionally attached to themselves, grandiose and self-focused. Of course, resolution is not dichotomous, but a matter of degree.

Although traditional psychoanalytic theory posits that self-image forms early in childhood, modern research suggests that self-image may remain malleable into the early 20s, since the prefrontal cortex,

involved in the development of self-image and understandings of how to react to others, develops slowly into the early 20s. During these years, specific environmental and relational circumstances are needed to guide brain development toward maturity. Karen Horney suggested that children “need to feel secure, to be loved, protected, and emotionally nourished...” to move out of primary narcissism (Vaknin, 2003). Frustration of these needs leads to narcissistic wounds and ongoing struggles to obtain love, safety, and value.

All people have inborn needs for love, acceptance, and security that include validation of their unique identities and age appropriate encouragement of autonomy. Environmental conditions that facilitate these needs provide children sufficient security to move beyond the narcissistic stage. If parents consistently reflect acceptance and joy, children learn, “I am acceptable and valuable. Even when I mess up, they still accept me, love me, and find joy in me. I can feel secure that I am loved and accepted.” If children learn that they are wanted and acceptable, they will not have to spend a lifetime trying to prove their worth and value. Once identity is firmly established and there is a foundation of security, it is safe to begin letting go of self-focus, learn empathy, and express genuine interest in others.

On the other hand, if children see disappointment or contingent acceptance in their parental mirrors, they believe they are disappointments and develop an ongoing struggle for acceptance. Kernberg (Frey, n.d.) viewed self-centered and grandiose narcissistic behaviors as defenses against cold and unempathetic parents. “Emotionally hungry and angry at the depriving parents, the child withdraws into a part of the self that the parents value, whether looks, intellectual ability, or some other skill or talent. This part of the self becomes hyperinflated and grandiose... , [and there is a] lifelong tendency to swing between extremes of grandiosity and feelings of emptiness and worthlessness.” Grandiosity becomes the compensatory strategy to deal with pervasive feelings of inadequacy, and focuses on what children perceived their parents to value. Accordingly, narcissistically wounded ED patients commonly come from families that value fitness and thinness and disdain people who are overweight.

If children do not experience validation, this narcissistic wounding obstructs and distorts the development of their identities, creating cavernous feelings of inadequacy and a constant need to seek out mirrors. The goal is to get the mirrors to reflect back a desirable image of self. Such individuals hope to see in others what they did not see in their parents: acceptance, joy, approval, a sense that they are special and important. When they see this image reflected back, they feel good. But sooner or later, the mirroring other will criticize or say “no” to the individual or focus on someone else. This perceived rejection becomes a narcissistic insult that opens up past narcissistic wounds, resulting in extreme pain and rage, known as narcissistic rage. Individuals then use compensatory strategies to deal with the pain and protect themselves from humiliation.

In this situation we see several components of the narcissistic process in action. Narcissistic wounding is exposed by a narcissistic insult, i.e., a response that replicates the original wound. Narcissistic rage follows, flowing out of the extreme pain of perceived rejection. Ultimately, compensation occurs to re-establish emotional equilibrium. With strong, ingrained compensatory strategies, individuals may move directly from insult to compensation; no one knows what occurred inside.

Psychoanalysis sees parents as the source of narcissistic wounding. Although sometimes true, we believe our culture, obsessed with accomplishments and status, separating winners from losers, also takes a huge toll on young people’s self-esteem. Peer culture can be horrendously cruel and is often the primary source of narcissistic wounds in ED patients. Below are examples of common narcissistic wounds.

### How Families Narcissistically Wound Children

Casting the child’s identity around a problem or disorder (e.g., “my problem child”) or, conversely,

around one of the child's gifts, talents, or attributes, as opposed to who the child is as a person.

Attributing behavioral problems in childhood to permanent character issues.

Routinely using shame, guilt, and/or fear to gain behavioral control of a child.

Constant ridicule and/or sarcasm, especially in the absence of genuine affirmation.

One parent allies with a child against the other parent, creating a dysfunctional family system that makes progression through the developmental stages difficult. The child is valued as a partner or ally, and not as a unique individual.

A family system that does not tolerate change or individuality, and so fails to recognize and validate the child's uniqueness.

Isolating the child from the external world (e.g., peers, other viewpoints), thus preventing the child from discovering mirrors of his/her soul.

Not filtering a child's contact with the world via age appropriate restrictions, leaving the child to feel unprotected and thus undervalued.

Inhibition and/or punishment of the separation/individuation process. Children are not allowed to develop their identities and are punished by rejection or criticism when they do, forced to choose between parental acceptance and identity development.

A parent spends very little time interacting with the child and seldom asks the child about her opinions and thoughts.

Physically/emotionally-abused children develop the belief that they are objects for others' wrath.

An environment that creates constant competition between siblings and uses that competition as a means of control. In such an environment, approval is always conditional.

An ADHD child is seen as bad by parents and/or school. This is especially wounding when siblings are well-behaved, high achievers.

A child is placed in an inappropriate role, such as confidante, go-between, or counselor to her parents. This role shapes her relational template such that she cannot set boundaries and becomes the caretaker in future relationships. Although she hates this role, it also makes her special as she is trusted to handle adult problems.

A female child is very close to her father. He suddenly reveals an affair and wants a divorce. She had absolute trust in her father and, in her view, this is direct abandonment/rejection of her. Her father chose another woman, knowing it would separate them. Regardless of his reassurances, the child is deeply wounded. Her feminine esteem is devastated: "Wasn't I enough to keep him here?" The other woman is often younger and thinner than mom, teaching the child the importance of body image in maintaining relationships.

Following a divorce, mom marries again and has a new child. The child from the previous marriage feels replaced by the new baby. There is hidden jealousy as the half-sibling is a full biological child in the new family, and has a father who loves her, an ideal family that is very different from the one the older child

grew up in, and an ideal childhood whereas the older child's was damaged. The sibling's life rubs salt into the older child's narcissistic wounds. The older child feels like an outsider, even a nanny. Her self-esteem is further injured by her own shame about her jealousy of the new child.

## How Peers Narcissistically Wound Peers

Something's wrong with you, so you don't belong. A child has a deficit, e.g., speech impediment, physical anomaly, clumsiness, intellectual slowness, social naiveté, lack of social skills. Too often having problems like these is like bleeding in the midst of sharks: it precipitates a coordinated attack from peers. For example, as many as 80 percent of middle school students engage in bullying behaviors. Many students tease their peers to go along with the crowd (Kittredge & McCarthy, 2000). The victimized children often do not understand why others single out and make fun of them. They conclude they must be horribly defective. The wounding can be enormous, following these individuals through life.

No one is going to love you. A teen is ignored by the opposite sex. She is never asked out. If she shows interest in someone she is rejected, often cruelly. She may feel competent in other areas, such as academics, but in the key area of dating, she is a misfit. She concludes that no one will ever want her and she is doomed to be alone. She curses her face and body. She may try to compensate by becoming immersed in areas of perceived strength, such as academics.

You're a loser, but you've got me! A peer latches onto an introverted child and makes her into her friend. Although the peer does enough to maintain the relationship, she seldom loses an opportunity to criticize or tease the shy child. The shy child learns to tolerate abuse as a condition of relationship. The cruel peer is dealing with her own sense of inadequacy through her one up status with her friend. The relationship keeps both children from being totally alone and makes them more acceptable to peers because they have a friend.

Join the club, pay the dues! Sexual activity is an expectation for inclusion in many teen social groups. "Girls from age 12 admit that pressure to have sex comes from all sides—boys, other girls, their friends and the media, [and] girls frequently cite incidents of boys as young as 12 or 13 calling [them] 'bitches,' 'sluts,' and 'whores' or making crude requests for sex" (Kittredge & McCarthy, 2000). Sexual pressure and promiscuity have narcissistically wounded many girls and women with EDs, as their identity becomes consumed within physical attractiveness. Guys may tell them, "I love you," but this often means, "I love your body." Girls lose sight of the difference between the two and feel valued only for their looks; the rest of who they are is devalued and unvalidated.

## Relational Templates

Object Relations Theory posits a relational template—a mental guide for relationships based on early family relationship patterns that continues to shape and guide relationships throughout one's life (Klee, 2007). Once formed, relational templates can be modified, "but our basic tendency is to seek out others, such as friends and spouses, who will reaffirm these early self-object relationships. It is as if in early childhood we create a script for a drama and then spend the rest of our lives seeking out others to play the parts" (Klee, 2007).

Seeking others to play the roles of key individuals from the past occurs by a process called projective identification. In mere projection, people attribute their own inner feelings, impulses, or experiences to other people. Projection is a passive process; we do not need others to act in a manner congruent with what we project onto them, we simply believe they are that way. Projective identification goes beyond

mere projection, as it involves active manipulation of another person to behave like a key person from our past, in order to replicate and reaffirm early self-object relations. Narcissistically wounded individuals often engage in projective identification and replicate their early wounding with others. Such patients frequently use projective identification with treatment professionals as well, e.g., attempting to maneuver the provider so the provider behaves like the overprotective or rejecting parent who favors another sibling. Without awareness of this process, providers are vulnerable to the projective identification and may enter into relational patterns that do indeed replicate a significant relationship from the patient's past.

It is important to understand that patients who use projective identification are not doing so malevolently or even consciously. They have simply learned to relate to others in this way. Some clinicians, when experiencing a patient's efforts to replicate a past relationship, will say: "She is just doing it for attention." It does not take a sophisticated professional to see that a patient craves attention. However, it does take experience and skill to know why patients are craving attention, to understand their relational templates, and to help them move beyond their unhealthy ways of receiving attention toward healthier methods that can potentially heal their narcissistic wounds.

### From Narcissistic Wounding to Personality

Narcissistic wounds may result in the personality characteristics of DSM-IV's NPD—arrogance, lack of empathy, focus on power, and entitlement. Our clinical experience with thousands of ED patients suggests that narcissistic wounds may also result in other personality characteristics, some quite different from NPD. The range of personality characteristics arising from narcissistic wounds varies according to each child's temperament, environmental conditions, and inherent and developed attributes, such as intellect, athleticism, and physical appearance. Common personality characteristics of narcissistically wounded individuals include:

Strong feelings of insecurity and inadequacy.

Fragile ego, being easily hurt and prone to become defensive.

Constant comparison of self with others.

Self-conscious and hypersensitive to the reactions of others.

Egocentric and self-focused, but not necessarily egotistical as in classic NPD.

Conflicts between dependency and autonomy, caused by insecurity and affirmation needs conflicting with distrust and fears of being hurt.

Extreme sensitivity to rejection, anticipating rejection or betrayal.

Difficulty accepting compliments, as they are likely to be conditional.

Sense of self-worth easily swayed by current circumstances and emotions.

Inner pain and rage, where rage may be turned toward others or oneself.

Chronic feelings of humiliation.

The methods that individuals develop to compensate for their narcissistic wounds vary and are by no means restricted to NPD behaviors. Narcissistic compensation is an effort to get other people to mirror back an acceptable image. As Vaknin (n.d.) writes:

We all search for positive cues from people around us... There is nothing special in the fact that the narcissist does the same... The normal person is likely to consume a moderate amount of social approval ... in the form of affirmation, attention, or admiration. The narcissist ... asks for more and yet more...

Vaknin (2003) continues by noting that narcissistic individuals project fictitious versions of themselves, known as false selves. For those with classic NPD, the false self is omniscient, omnipotent, charming, intelligent, rich, or well-connected. The purpose of the false self is to gain the validation the individual craves. For narcissistically wounded individuals, the false self may not always be grandiose, but can take a variety of forms. Any false self that garners the needed attention will do.

Most ED patients are painfully aware of their false selves. On countless occasions I have listened to patients talk about their masks. They wear masks because they have a core belief that the person they are inside is unacceptable and must be covered up. This belief is not innate; somewhere along the way they experienced extremely painful events that burned this message into them.

Operating within a cognitive-behavioral therapy (CBT) framework, Beck described methods of compensating for perceived inadequacies as compensatory strategies (Beck, Freeman, Davis, & Associates, 2003). Compensatory strategies protect individuals from further relational pain, partially meet their needs for acceptance, identity, and worth, and shield individuals from their inner pain, emptiness, shame, and aloneness. Compensatory strategies begin in childhood and continue throughout individuals' lives. Although these patterns can change, especially during crisis, they usually become ingrained. For some, compensatory strategies are so deeply ingrained that the individuals no longer experience their insecurity. Nevertheless, it continues to drive their actions.

The following examples demonstrate common false selves—the compensatory strategies of the narcissistically wounded.

Seeking to be the best, e.g., in academics, sports, business, evangelism.

Seeking to be the most beautiful, sexually desired, or thinnest.

Seeking an ideal romance or the perfect relationship in the belief that this relationship will finally meet the unmet needs for acceptance and validation.

Reverse or closet narcissism: “If I am not the best, then I will be the worst.” The individual does not present a grandiose, inflated false self, but a deflated, inadequate self (Masterson, 1981); e.g., being the sickest or the one with the most trauma. This leads others to caretake, reassure, build up, pay attention, and validate the individual's heroism.

Seeking to be needed and indispensable through caretaking others.

Convincing others that they need the individual.

Constantly drawing attention back to oneself. E.g., when someone tells a story, the person often responds, “That's nothing, I...”

Being dependent, eliciting nurturance missed early in life.



Constantly putting others down, gossip, backbiting. In contrast, one's identity appears acceptable and/or elevated.

Arrogance and superiority.

Façade of adequacy and independence.

Exerting power over others by physical force, position, or emotional manipulation/intimidation/control, to force others' respect and prevent others from further wounding the individual.

Seeking fame or high status.

Vicarious Narcissism: living through another person or group of persons, often one's children or high status figures/celebrities. The individual gains validation by identification with the other person's accomplishments. We discuss vicarious narcissism in more detail below.

Vicarious narcissism occurs when individuals gratify their narcissistic needs through other people. Personal boundaries blur as individuals react to another person's experience as if those experiences were their own.

Vicarious Narcissism can occur in fans' identification with athletic teams. Some fans over-identify with athletic teams, as if they were members of the team. When the team wins it is a personal victory for the fan; when they lose it is a personal loss. The language used demonstrates the blurring of identity, "we're gonna kill 'em". In many cases this is benign. In the extreme, some narcissistically wounded fans take this to the point of violence, when the team lets them down or they believe an official caused the loss of a game.

Celebrity stalkers gratify unmet narcissistic needs through fantasy-based relationships with the celebrity. The celebrity's high status combines with the fantasized connection; the stalker feels important and special. Sadly, this too can end in violence, especially when the stalker tries to make contact with the celebrity and is rejected or ignored—a narcissistic insult leading to narcissistic rage.

When rejected or betrayed, some lovers and would-be lovers demonstrate narcissistic rage by violent attacks, including murder. Police often know that the murderer had a romantic connection with the victim because of the extreme nature of the attack, going well beyond what was necessary to kill the individual.

In some parent-child relationships, the child is used as an object through which parents meet their narcissistic needs for attention and affirmation. Rappoport (in press) refers to the child in this scenario as a co-narcissist who must accommodate narcissistic parents. "Co-narcissistic people, as a result of their attempts to get along with their narcissistic parents, work hard to please others, defer to other people's opinions, worry about how others think and feel about them, are often anxious and depressed...." Narcissus loved his own image. Accordingly, if you want a narcissistic person to love or accept you, you need to look and act like that person. If you want a narcissistic parent to love and accept you, you need to be exactly like that parent. Narcissistic parents "...see the children as extensions of themselves, and need the children to represent them in the world in ways that meet the parent's emotional needs.... The children are punished if they do not respond adequately... including physical abuse, angry outbursts, blame, attempts to instill guilt, emotional withdrawal, and criticism." Because we are ultimately incapable of meeting another person's narcissistic needs, these children fail. They thus develop narcissistic wounds in

two ways: not being allowed to develop their own identities and failing at their primary role in the family.

## Narcissistic Wounding and Body Image

Individuals in our culture, especially women, are often judged by physical appearance more than other attributes. In essence, females are taught, “You are your body.” Objectification Theory asserts that sexual objectification is the treatment of a woman’s body as an object for the pleasure and use of others (Slater & Tiggeman, 2002). Sexual objectification is so pervasive and its influence so strong that it causes females to internalize this objectification of their bodies. Girls and women “adopt an observer's perspective... [and] treat themselves as an object to be looked at and evaluated on the basis of appearance.” This internalization, called self-objectification, is “...characterized by habitual and constant self-monitoring of one’s outward appearance.” Self-objectification leads not only to body monitoring, but also to appearance anxiety and body shame. In Remuda’s extensive experience, body shame clearly plays a direct causal role in the development and maintenance of EDs.

In light of these cultural pressures, one can see that ED individuals’ perceptions about the importance of physical appearance cannot simply be dismissed as irrational thinking. Indeed, studies have found evidence of positive bias toward those deemed attractive. A meta-analysis found that people who are perceived attractive are judged more favorably in a variety of areas and treated more positively, including in employment decisions (Langlois, et al., 2000; Marlow, Schneider, Nelson, 1996).

Objectification Theory adds to our understanding of body image issues in ED patients suffering from narcissistic wounds. A woman experiences her body as an object. She is aware that her body can bring her acceptance in high status groups, the interest of high status males, prestige, preferential treatment, attention, affirmation, and more. She becomes vulnerable to the cultural messages about appearance and internalizes the culture’s perspective, including the extreme importance it places on appearance. Since she already experiences her body as an object, in the manner of vicarious narcissism, she views her body as the vehicle to meet her narcissistic needs for acceptance, identity, and worth.

In vicarious narcissism, when the object fails to supply validation, the individual rages at the object. Likewise, when she feels unacceptable or is rejected, she rages at her body. She calls herself a “fat pig,” punishes her body, and tries to whip it into shape. She restricts how many calories her body may consume and eliminates pleasurable food items. She engages in nonstop compulsive exercise where each calorie consumed is matched by calories burned in exercise. She self-mutilates. But ultimately her body cannot meet her needs to be accepted, loved, and seen as special. First, it will let her down, because bodies are imperfect. Second, whatever acceptance she manages to gain through her appearance is conditional, and does not truly validate who she is inside. Her narcissistic wound remains. But because physical appearance is so highly valued in our culture, she will continue to blame her unhappiness on her body and believe that she will be happy if she could “just lose 15 pounds...”

Extremely attractive girls and women are highly reinforced for their appearance. They must constantly monitor and protect their beauty because they often do not know their value without it. The ED is a way of insuring that they will not become fat, which would equate to losing the much needed reinforcement that soothes the narcissistic wound.

Others, less sure of their appearance, succumb to the incredible value that our culture places on appearance and are driven to prove to themselves that they are attractive. They dress provocatively and become promiscuous. Subsequent male attention gives these women evidence that they are attractive. However, sexual experiences cannot fill the void within. Rather than increase self-esteem, promiscuity often leads to shame. Such women may self-harm, binge eat to numb their emotional pain, then purge out of fear of getting fat and losing the affirmation they gain through their appearance. Some women are

trapped in this process, as their need to prove their worth remains unquenched.

For some, their appearance itself has been a narcissistic wound. They were teased by peers for their appearance, ostracized, and tortured through tricks and taunting. Sadly, childhood obesity can elicit such peer cruelty. ED patients with histories of childhood overweight have what I call, the trauma of obesity. These children were truly traumatized. Post traumatic stress disorder includes efforts to avoid activities, places, or people that arouse recollections of the trauma. For these individuals, their own body, as an object, is the source of trauma. In their view, the ED prevents their body from losing control, gaining weight, and returning them to the trauma.

## Treatment Issues

Whether a narcissistic wound manifests in classic NPD symptoms or otherwise, the wound can make therapy difficult. Through projective identification the patient will actively attempt to get the provider to take on a specific role to replicate past conflicts. The patient can be highly frustrating, expecting and perceiving rejection from the therapist. Without recognizing this, providers can play into the projective identification, becoming impatient and critical, and reporting to colleagues, “this patient doesn’t want to get better and isn’t motivated.” Patients with an ingratiating compensatory style can have the opposite effect. Providers feel sorry for them, may believe other staff are being unfair to these patients, and may allow patient dependency without recognizing it.

## Essentials of Treatment

Treatment involves several key ingredients that can be offered from CBT or psychoanalytic perspectives.

**Assess Issues.** Find out if there have been significant narcissistic wounds by taking a good history. Patients’ emotional functioning is based on their perceptions, regardless of how accurate they are. The goal is not to blame parents or take sides, but to understand how patients see themselves and the world. The basic components of narcissistic wounding in this article will help in this assessment. It is also important to learn how patients compensate for their wounds, and the role the ED plays in this compensation.

**Validate Wounds.** Start with the wounds. Help patients talk about them. Not talking about their wounds is an obstacle in treatment. Patients must express their wounds, but if they will not move beyond their wounds and choose to hold onto them, they will not heal. Providers need to validate the wounds. Validation means recognizing that someone hurt the patient badly, whether or not this took place exactly as the patient reports. People do not have severe emotional problems simply because they want to have such problems. Even if patients are seeking attention, emotionally healthy people do not go to extremes to get attention, so it is essential to recognize and validate that something truly painful has happened to our patients. Patients need to understand that they were hurt badly and that their problem behaviors are their best attempts to deal with their pain. This greatly reduces patients’ shame, without reducing their responsibility to do something about their situation.

**Teach Relational Templates.** Both Object Relations and CBT recognize that individuals create templates/schemas that guide how they interpret events in their lives. It is important to understand these templates. Once assessed, begin by helping patients to recognize their patterns. Help patients understand their patterns and compensatory strategies as attempts to handle problems in the best ways they have known, while communicating that they can develop new ways.

**Teach New Skills.** Recognizing patterns and gaining insight without the tools to make changes does not lead to sufficient change. CBT skills are critical. Patients need to recognize how their past learning

impacts how they interpret events and how to challenge these interpretations. The most critical aspect of this is not changing irrational thinking, but providing patients with cognitive, behavioral, and emotional skills that allow them to form healthy relationships, being cognizant of old patterns and inserting new skills to take their place.

**Address Spiritual Issues.** Narcissistically wounded people have distorted identities built on superficial and fragile foundations. They must learn that they are special, unique, and acceptable, even though their compensatory behaviors may push people away. Their need for compensation is built upon a false premise—that they are unimportant. As they learn exactly how important they are, their need to compensate can dissipate in time. Learning about their value can be enhanced through spiritual considerations. We address spiritual considerations in more detail below.

### Spiritual Considerations

Some Christians are suspect of positions that affirm the importance of self-esteem and self-worth. They point to Scriptures such as Jesus' call to deny ourselves and take up our cross (Matthew 16:24). This is an understandable reaction to concerns that our culture has grown hedonistic and selfish, the "Me Generation".

God is uninterested in feeding self-centered desires for fame, supremacy, or admiration, or in rewarding arrogance. The desire to be worshiped was the very sin that caused Lucifer's fall (Isaiah 14:11-23). The desire to be like God was also key to Adam's and Eve's disobedience. Christians are not called to be lovers of self (2 Timothy 3:2). The Greek word for love in this verse refers specifically to a self-indulgent love bent on one's own pleasure and gain.

Scripture makes clear that the opposite of hedonistic love is equally wrong. "Let no one keep defrauding you of your prize by delighting in self-abasement..." (Colossians 2:18, NAS). "Don't let anyone condemn you by insisting on self-denial" (Colossians 2:18, NLT). Self-abasement is a sense of moral littleness, shame, and low self-esteem. Scripture tells us that God does not want this for us. In fact, self-abasement is a form of false humility. Those who engage in self-abasement often feel self-righteous inside: they are proud of their self-denial.

Rather, we are called to true humility. True humility understands that our worth is not based on any of our attributes, but on the fact that we were intentionally created in God's own image. In Matthew 19:19, Jesus commands us: "You shall love your neighbor as yourself." The word used for love is agape, a charitable and giving type of love involving action. We are commanded to love our neighbor as ourselves, because it is understood that we already love ourselves. And the fact that we already love ourselves in the manner of agape is assumed to be good—so good, that we are commanded to extend this love to others.

As such, humility does not flow out of low self-esteem or a lack of self-worth. Humility, in its greatest expression, was evidenced by God choosing to become a man, serving others in agape love, ultimately dying for them. Although powerful, Jesus chose to be humble out of love. As such, humility involves choice and power, the choice and power to love others. As the Bible tells us in Philippians 2, we should "...with humility of mind regard one another as more important than yourselves..." The Bible does not say that we are less important than others, but tells us to regard others as more important as an act of agape love.

People narcissistically wounded in childhood have either a very weak or false sense of control. They have a false power or feel that they lack power altogether. Narcissistically wounded people do not have the power to be humble; they are either arrogant or have such incredibly low self-esteem that they constantly hide behind a facade. In the Greek New Testament, humble means "to lower to the ground". How can

someone who is already extraordinarily low in their own perception choose to lower themselves any further? They cannot.

People with wounded self-worth focus on themselves, much like someone with a migraine headache has a hard time focusing on anything but the headache. Only when we feel valued and significant are we capable of thinking about others above ourselves. C.S. Lewis (2001) wrote, "...if you meet a really humble man he will ... not be a sort of greasy, smarmy person, who is always telling you that ... he is nobody. Probably all you will think about him is that he seemed a cheerful, intelligent chap who took a real interest in what you said to him. If you do dislike him it will be because you feel a little envious of anyone who seems to enjoy life so easily. He will not be thinking about humility: he will not be thinking about himself at all."

Children go through a narcissistic, self-focused stage. So how does a child move out of that narcissistic stage? The parent loves and lifts up the child; the child then learns how to return this love. Christians go through an analogous realization of our sinfulness and lack of worth. How does God deal with our lowly position and shame? He loves us and lifts us up; then, in response, we love him. "We love because He first loved us..." (1 John 4:19). Without the love of God we would remain self-absorbed. His love and building us up set us free and give us the choice to be humble. The same type of love, reassurance, and validation that God gives us are exactly what children need to form strong egos that can choose to value others and put others' needs above their own.

God recognizes and values our desire to be significant. For example, Jesus' disciples came to him asking which of them is greatest (Luke 9). Jesus did not tell them that their desire to be great and significant was wrong. Rather, He told them that their method was wrong. He affirmed that it is right to want significance, but that we do not become significant by lording our will over others. We become significant by choosing to serve and care about others in love.

Our culture has departed from valuing what leads to self-esteem. We admire and envy the rich and powerful, we worship the beautiful and talented, we call students with good grades "honor students," when, in some cases, their moral character may demonstrate anything but honor. We live in a society where status derives from winning at competitions, whereas God wants us to cooperate and help each other succeed. Our schools teach survival of the fittest to explain how human beings evolved. Children are taught that living creatures compete for limited resources and that the winner gets to live and reproduce, implying that nature favors the strong, the fast, and the intelligent, and rewards those who possess these traits with survival. Life is just one big competition. Athletes have multi-million dollar contracts; teachers are poorly paid. Our culture suffers from the curse of "est"—the need to be the strongest, smartest, fastest, prettiest, thinnest, "baddest", richest, and toughest. So self-esteem is based upon being the best, but the only way for one person to be the best is for others to lose.

Narcissistically wounded individuals lack self-esteem and value, so they constantly try to obtain value and worth. To do so, according to our culture, they must win and be better than others: this will make them special. As such, countless girls are competing with their peers to be the thinnest.

God created all of us with a legitimate desire to be special. This means that we are irreplaceable, but not better than anyone else. Jesus talks about going after one lost sheep and leaving the other 99 to do so (Luke 15). The message is clear: everyone is irreplaceable. Without this core Biblical understanding of our value, we fill the void with lovers, money, power, EDs, substances, and so on. Yet the Bible wisely counsels: "Why spend money on what is not bread and your labor on what does not satisfy? ... [E]at what is good, and your soul will delight in the richest of fare" (Isaiah 55:2).

With this Biblical understanding of self-esteem, Christian therapy proceeds as follows. It builds trust to

touch the wounded place, so that patients can receive affirmation of their importance as persons uniquely desired and created by God—not as bodies, grade point averages, or athletes, but as souls. Wounded persons must discover that it is safe to admit their dependence on God and receive their value from a healthy relationship with God and others. Wounded people are educated about how they have sought apart from God to meet their God-given needs for identity, worth, love, acceptance, security, and significance. These goals are important and valid, but their compensatory methods are ineffective and will never heal their inner emptiness. Wounded patients are assisted in developing new and effective ways to meet their needs. Yes, they need support and validation from other people, but they do not need to become dependent on anyone. Just like children need positive mirroring, wounded patients need others to reflect back to them the worth that God has given them. And they need to look directly into the heart of God, who radiates his pleasure, love, and acceptance of them through the redeeming grace of Jesus Christ. “For God so loved the world, that He gave his one and only Son, that whoever believes in him shall not perish but have eternal life” (John 3:16). “And I pray that you, being rooted and established in love, may have power, together with all the saints, to grasp how wide and long and high and deep is the love of Christ, and to know this love that surpasses knowledge—that you may be filled to the measure of all the fullness of God” (Ephesians 3:17-19).

## References

- Beck, A., Freeman, A., Davis D. & Associates. (2003). *Cognitive personality disorders*, (2nd ed.). New York: Guilford.
- Brunton, J.N., Lacey, J.H., & Waller, G. (2005). Narcissism and eating characteristics in young nonclinical women. *Journal of Nervous and Mental Disease*, 193, 140-143.
- Cassin, S.E. & von Ranson, K.M. (2005). Personality and eating disorders: A decade in review. *Clinical Psychology Review*, 25, 895-916.
- Daniels, V. (2007). Object relations theory. Retrieved June 9, 2008, from <http://www.sonoma.edu/users/d/danielsoobjectrelations.html>
- Frey, R.J. (n.d.). Narcissistic personality disorder. *Encyclopedia of mental disorders*. Retrieved June 9, 2008, from <http://www.minddisorders.com/Kau-Nu/Narcissistic-personality-disorder.html>
- Kittredge, K. & McCarthy, A.R. (2000). Peer pressure: Today’s youth face pressures from many unprecedented factors. *The Brown University Child and Adolescent Behavior Letter*, 16. Retrieved June 9, 2008, from <http://www.childresearch.net/RESOURCE/NEWS/2000/200006>
- Klee, T.O. (2007). Object relations theory: Key concepts. Retrieved June 10, 2008, from <http://www.objectrelations.org/orkey.htm>
- Langlois, J.H., Kalakanis, L. Rubenstein, A.J., Larson, A. Hallam, M. & Smoot, M. (2000). Maxims or myths of beauty? A meta-analytical and theoretical review. *Psychological Bulletin*, 126, 390-423 as cited in PsychNET. doi:10.1037/0033-2909.126.3.390
- Lewis, C.S. (2001). *Mere Christianity*. New York: HarperCollins.
- Marlow, C., Schneider, S., & Nelson, C.E. (1996). Gender and attractiveness biases in hiring decisions: Are more experienced managers less biased? *Journal of Applied Psychology*, 81, 11-12.
- Masterson, J. (1981). *The narcissistic and borderline disorders: An integrated approach*. New York:

Brunner/Mazel.

Rappoport, A. (in press). Co-Narcissism: How we accommodate narcissistic parents. *The Therapist*. Retrieved June 10, 2008, from <http://www.alanrappoport.com/Co-Narcissism%20Article.pdf>

Sines, J., Waller, G., Meyer, C., & Wigley, L. (2008). Core beliefs and narcissistic characteristics among eating-disordered and non-clinical women. *Psychology and Psychotherapy: Theory, Research and Practice*, 81, 121-129.

Slater, A. & Tiggeman, M. (2002). A test of objectification theory in adolescent girls. *Sex Roles*. 46, 343-349.

Vaknin, S. (n.d.). Narcissism at a glance. Retrieved June 9, 2008, from <http://samvak.tripod.com/narcissismglance.html>

Vaknin, S. (2003). Malignant self-love: Narcissism revisited. Retrieved June 9, 2008, from <http://samvak.tripod.com/narcissisticsupplyessay.htm>

### Case Study: Narcissism and Bulimia Nervosa

Sherrie L. Maher, PhD  
Remuda Ranch Programs for Eating Disorders

Julie, age 19, came to Remuda following an intervention. She was well dressed, consistent with the latest in fashion. Her father was a respected surgeon, her mother a homemaker raising Julie and her older sister. Julie's parents had reached their limit with her bulimia, and had locked the refrigerator to stop Julie from binge eating.

Julie's mother had once been in beauty pageants. At Julie's age she had represented her home state in a nationally televised pageant, placing 3rd. Julie was born with her mother's stunning physical appearance and was expected to follow in her footsteps. As such, Julie was enrolled in beauty pageants starting at age three.

Julie recalled that her mother would work with her for hours, teaching her to walk with grace, practicing poses, and developing her singing. Julie's singing scored many points at pageants. But when she did not meet her mother's singing standards, her mother would scream at her and accuse of her intentionally trying to sabotage her mother's hard work. Julie's mother often told Julie about how hard she had worked at pageantry and how she would have been successful and famous if she had not become pregnant at age 21. Now it was Julie's chance to make something special of herself. She needed to try harder. As part of Julie's training, her food and exercise were carefully monitored.

Julie's sister, Andrea, was their father's favorite. Her sister took after their father in temperament and was thinking about medical school. Julie secretly yearned for her father to love her as well, but she could never talk to anyone about that. Besides, she told herself, she had more friends than Andrea.

During collateral interviews, Julie's father revealed that Julie had always exhibited a great deal of rage. This was especially true when things did not go her way or she was criticized. About two months ago, Julie had ripped an expensive pageant dress to shreds because she could not get the zipper to work. Julie was also hostile and cruel to her sister.

Andrea revealed that she goes out of her way to avoid making Julie angry, so as not to trigger Julie's

screaming fits. Andrea indicated that Julie often takes things the wrong way and as criticism. In retaliation, Julie points out her sister's flaws, often making extremely cruel comments about Andrea's appearance. Julie admitted that she often screams at her sister and that she is extremely critical of her. This had created a distance between them.

Julie saw herself as popular and having tons of friends, however she did not seem to have any deep friendships. She was the life of the party and knew she was extremely attractive to men of all ages. She saw herself as a femme fatale and a "man eater." Julie believed that when she was thinner she was "even more of a threat to men" and therefore could have any man she wanted. She had an extensive sexual history and talked about it as an accomplishment. Although her mother never openly approved of how much Julie dated, her mother often boasted to family and friends about how, "the boys just won't leave Julie alone. I just don't know what I am going to do."

Julie clearly evidenced criteria of narcissistic personality disorder. I learned that her bulimic behaviors were entwined with her narcissistic issues. She would binge eat, at least in part, to get even with her family, especially her mother, because their fear for her well-being and concern that she might get fat were easily manipulated. She purged, fasted, and restricted calories, because of how important her appearance was to her in obtaining attention and affirmation from others.

Julie's psychological testing indicated that she would have a difficult time developing insight into her own motives and behaviors, as well as those of others. She would likely have somatic problems to procure attention or avoid responsibility. Julie reported that, when sick, she received more attention from her father. In fact, her father had been much more attentive to her since she was diagnosed with bulimia.

At Remuda, Julie was very demanding with staff. She raged, sometimes at drop of a hat. She took on a condescending and superior attitude with staff and all but a few select peers. In classes, Julie always volunteered and emerged as the leader of discussions. During meal times, Julie hid food on her body and resorted to other means to avoid eating. Once discovered, staff began to check her after meals. Rather than accepting responsibility for her behaviors, Julie often blew up at staff, talking about how unfairly they treated her, even when it was obvious to everyone, including herself, that she had indeed hid her food.

In therapy, it became clear that Julie had a very fragile ego, despite her outer appearance of confidence and power. She was like a house built on the sand, without a foundation to hold her. Julie had to be approached very carefully in therapy. Although it was important from the start to help her understand the guidelines for behavior in the milieu, confronting her attitudes and behaviors in therapy sessions resulted in power struggles such that entire sessions were spent arguing about whether or not the rules were fair or why they had been applied to her.

Clearly, before she could be challenged on her behaviors and the need to take responsibility for her actions, she first had to become aware of her needs and wounds and have these needs and wounds validated. Her wounds included feeling that her father loved her sister more and that her father was proud of her sister, highly valuing her sister's academic success and "what a mature young lady she is becoming." Julie knew her father loved her, but never felt that he was proud of her or who she was becoming as a person. Her wounds also included her sense that she had to be a clone of her mother if she wanted her mother's love, attention, and respect. She had to become what her mother wanted her to become, value what her mother valued, and never deviate from her mother's plan for her life. If her opinion differed from her mother's or she did not share her mother's passion about something, her mother screamed at her, or worse, stopped talking to and working with her. In these cases, she was made to feel guilty for having her own opinion. Her mother would say, "Fine if you want to throw away all that we have accomplished. I have sacrificed so much for you, and you don't even care." Julie's guilt would lead her to apologize. In short, it was not okay for Julie simply to become who she was created to be.



Much time was spent in therapy addressing the crucial issue of naming, explaining, and validating Julie's wounds. The danger at this stage of therapy was that Julie might blame her mother and simply redirect her anger. Therefore, Julie had to learn that, at this point in her life, she needed to be responsible for choices. She did not need blame herself or beat herself up emotionally, but to learn new ways to regulate her emotions, to meet her needs based on what is truly healthy for her, and to communicate, especially with her family. These themes and the impartation of skills were woven consistently into Julie's individual and group sessions, as well as her experientials.

Spiritually, Julie needed to learn that God is loving and accepting. Julie was a Christian, but did not experience God's love or favor. Her faith deepened through attending daily chapels at Remuda and near the end of treatment she began practicing the presence of God, to experience his comfort and love in a palpable way. She appeared to be opening to this. Indeed, she was finding a new path for herself. She realized that her sexual promiscuity only helped her to feel better temporarily, which is why she went from guy to guy. Her growing faith and experience of God's grace were enabling her to realize that what she wants from a man is not just physical love and validation, but love for who she is as an individual. Her awakening faith also helped her to release deep feelings of shame arising from years of her mother's criticism and her own cruel behaviors toward her sister and other people.

Halfway through treatment, Julie seemed to be developing some empathy for others, but still has work to do in this regard. She was treating other patients with greater respect and felt more accepted by the group as a whole.

With much preparation through family teleconferences, Julie's truth in love sessions during Family Week were successful. Julie reached some insight into her mother's past experiences and the pain her mother carries, and her mother was able to see how she was trying to make up for her own insecurities through Julie. Issues with Julie's father were only lightly addressed. The family clearly needed substantial additional family work; this became part of the aftercare plan. In addition, it was recommended that Julie's mother pursue individual therapy, as she began to recognize her own wounds, including feelings that she was not getting the attention from her husband that had once been there.

It would be nice to say that by discharge she was beyond raging, but she was still losing control of her anger at times. She completed several behavior chain analyses, which taught her to look at internal and external events leading up to a rage episode, as well as her thoughts and interpretations of situations. These exercises helped her to recognize potential rage episodes early in the process when they are easier to control and decreased the frequency of her rage episodes. Another change was that, after having a rage episode, she was able to recognize why she raged in that situation, and thereby discover what she could do to change the outcome next time. At discharge, we were optimistic that over time she would continue to understand her internal attributions well enough to avoid most episodes of rage.

Next Issue: Medical Issues and Eating Disorders

- [Twitter](#)
- [Facebook](#)
- [LinkedIn](#)

Call Intake At · 800.244.4949 | Other Inquiries · 800.632.3697

- [About](#)
- [Conditions We Treat](#)
- [Admissions](#)

- [For Health Professionals](#)
- [For Families](#)
- [For Alumni](#)
- [Contact](#)
  
- [Events](#)
- [Locations](#)
- [News](#)
- [Resources/Articles](#)

## **Wickenburg**

1 E Apache St.  
Wickenburg, AZ 85390

## **Chandler**

111 S Hearthstone Way  
Chandler, AZ 85226