Narcissistic Personality Disorder: Progress in Recognition and Treatment

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Abstract: This review will address pathological narcissism and narcissistic personality disorder (NPD)—the clinical presentation, the challenges involved in diagnosing NPD, and significant areas of co-occurring psychopathology (i.e., affective disorder, substance usage, and suicide). Major depressive disorder is the most common comorbid disorder in patients with pathological narcissism or NPD. Need for self-enhancement and chronic disillusionment with self make these individuals particularly susceptible to substance use. Suicidal preoccupation in these patients is characterized by the absence of depression, lack of communication, self-esteem dysregulation, and life events that decrease self-esteem. The diagnostic focus on patients' external characteristics and interpersonal behavior tends to dismiss the importance of their internal distress and painful experiences of self-esteem fluctuations, self-criticism, and emotional dysregulation. A collaborative and exploratory diagnostic approach to pathological narcissism and NPD is outlined that aims at engaging the patients and promoting their curiosity, narration, and self-reflection. Alliance building with a narcissistic patient is a slow and gradual process and mistakes are common. A central task is to balance these patients' avoidance and sudden urges to reject the therapist and drop out of treatment with the goal of encouraging and enabling them to face and reflect upon their experiences and behavior. Implications for treatment and possible areas or indications of change include: interpersonal and vocational functioning; sense of agency and self-direction; emotion regulation and ability to understand, tolerate, and modulate feelings; reflective ability; and ability to mourn the loss of wished for or unreachable internal self-states, relationships, and external ideals.

Introduction

Case vignette #1: "striving for perfection and facing despair"

Ms. B, a 24-year-old research assistant in biotechnology, began treatment after her second near-lethal suicide attempt. She described herself to the therapist as the top achiever in her lab, very meticulous and determined to do research projects according to optimal scientific standards in order to reach reliable results. However, despite evidence of her competence, Ms. B struggled with the horrific fear of making mistakes. Her internal requirements for absolute perfection combined with extremely harsh self-criticism caused constant doubts that her work would meet the standards she had set up for herself. She spent a lot of time studying and preparing to make sure that her supervisor, whom she admired for his exceptional skills and reputation, acknowledged her and supported her plans for a career in the field. She described recurrent episodes of getting trapped inside herself on a rollercoaster of aspirations and ambitions, demands, self-criticism, self-hatred, doubts, and fear, especially when facing new tasks and projects. At those times, she lost her ability to think clearly and concentrate and began to think about suicide. Usually she managed those situations by excessive alcohol consumption, but she had also begun to come in late and even cancel work. On two

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occasions she felt such fear of losing her competence—and hence her reputation in the lab and appreciation from her supervisor—that she saw ending her life as the only way out. Ms. B did not suffer from a major depressive disorder. Nevertheless, she had intermittent mood fluctuations that coincided with rapid shifts in her self-regulation, i.e., in her sense of agency, self-esteem, and self-judgment.

CASE VIGNETTE #2: "SEEKING COMPETITION BUT FINDING STAGNATION"

Mr. M, a successful financial investor in his early 50s, began psychotherapy after facing an ultimatum from his wife of 30 years who had threatened to leave him if he did not seek treatment and change his attitudes and behavior. Mr. M described himself as a committed, goal-oriented, and success-focused man, but one also in need of many parallel intense activity tracks, including competitive sailing and extramarital affairs, to balance what he described as a deep internal darkness that he had suffered from since early childhood. Easily irritated by others' inconsistency and imprecision, he also described himself as distant, unempathic, and self-preoccupied. But most importantly he struggled with a sense of emptiness and frustration of never reaching the satisfaction and sense of accomplishment that he so intensely desired. He felt guilty for not being a good husband, and although he loved his children and adored his grandchildren, he felt distant, struggled with urges to leave, and experienced a sense of deeper diffuse guilt, as if he did not deserve or could not embrace the fact that he indeed meant something and contributed to both his family and company. He felt trapped, unable to pursue what he really wanted in life, and asked the therapist if there indeed was any help for this condition.

These case vignettes show a range of clinical presentations and level of functioning in people with narcissistic personality disorder (NPD), with common underlying fragility and regulatory patterns. They also highlight the variable motivation in people with NPD that reflect the complex, unintegrated nature of their sense of self and identity. This review of NPD will address pathological narcissism, the clinical presentation and diagnosis of NPD, significant areas of co-occurring psychopathology (e.g., substance usage and suicide), and treatment modalities and some treatment considerations.

PATHOLOGICAL NARCISSISM AND THE DIAGNOSIS OF NPD

NPD is diagnostically defined in the DSM (1) as a pervasive pattern of grandiosity, need for admiration, and lack of empathy, with interpersonal entitlement, exploitiveness, arrogance, and envy. No changes in the diagnostic criteria for NPD are expected in DSM-5 (2). Additional characteristics frequently found in patients with NPD are perfectionism and high standards, feelings of inferiority, chronic envy, shame, rage, boredom and emptiness, hypervigilance, and affective reactivity (3–6). Empirical studies have also confirmed that internal emotional distress, interpersonal vulnerability, avoidance, fear, pain, anxiety, and a sense of inadequacy are associated with narcissistic personality functioning (7, 8).

Narcissism ranges from healthy and proactive to pathological and malignant. Pathological narcissism can be expressed in temporary traits or in a stable, enduring personality disorder. Both pathological narcissism and NPD can co-occur with consistent areas and periods of high functioning, sense of agency, and competence, or with intermittent qualities, capabilities, or social skills. Independent of the level of severity, pathological narcissism can either be overt, striking, and obtrusive or internally concealed and unnoticeable (9, 10). Recent research has confirmed two types of NPD, one grandiose, arrogant, assertive, and aggressive and another vulnerable, shy, insecure, hypersensitive, and shame-ridden. Each individual presentation of NPD can include traits and patterns of both phenotypes (7, 8, 11).

As a personality disorder, NPD is best identified in terms of self-regulation with fluctuating self-esteem ranging from grandiosity (in fantasy or behavior) and overconfidence to inferiority and insecurity, with self-enhancing and self-serving interpersonal behavior, high standards and aspirations, intense reactions to perceived threats, and compromised empathic ability.

In addition, depressivity, i.e. features related to depressive temperament and depressive personality disorder (12, 13), can co-occur with hypersensitive narcissistic personality functioning. The prevalence of NPD varies from 0%–6% in general population, 1.3%–17% in clinical population, and 8.5%–20% in outpatient private practice (14). Since co-occurrence of NPD with other personality disorders is common, it is important to identify the discriminating features, especially since narcissistic personality functioning can have significant treatment implications (15) (Table 1).

Narcissistic personality functioning and NPD have also gained considerable societal recognition, especially within corporative, organizational contexts. Exploitation of power and trust as a consequence of narcissistic work ethics and leadership has been documented, as well as the opposite, i.e., charisma and courage to implement constructive extraordinary changes or visionary goals.

Table 1. Narcissistic and Near Neighbor Personality Disorders

Personality Disorder	Narcissistic Personality Disorder (NPD) Comparison
Antisocial personality disorder (ASPD)	Absence of recurrent antisocial behavior; less systematic and conscious exploitiveness
Borderline personality disorder (BPD)	Absence of self-injurious behavior, identity diffusion, and intolerance of aloneness; NPD identity is based on idealization of self, devaluation of others, and compromised awareness of realistic qualities of self
Histrionic personality disorder (HPD)	Absence of warmth, dependency, and genuine commitment and concerns
Obsessive-compulsive personality disorder (OCPD)	Perfectionism associated with *being* perfect, having status, self-esteem, and avoiding shame (NPD), as opposed to *doing* things perfectly, having control and order, and being self-righteous (OCPD)
Paranoid personality disorder (PPD)	Absence of pervasive distrust or search for hidden motives; belief that other people envy them and want to hurt or counteract them.

The narcissistic patient

Patients with NPD can be professionally successful, consistently high-functioning, and socially well-connected (7), but they can also present with functional impairment, either with severely disabling narcissistic traits and character functioning, with accompanying mental disorders (16) or with malignant, antisocial, or psychopathic traits (17, 18). Changes toward worsening as well as improvement in narcissistic functioning are often influenced by real-life experiences that can be either threatening and corrosive or encouraging and corrective (19). Patients can also present and experience themselves differently in different social or interpersonal contexts; i.e., the same individual may present as dominant and assertive in one setting and in another as avoidant and easily humiliated, struggling with feelings of envy or resentment. In addition, certain circumstances can aggravate narcissistic traits in response to threatening or traumatic experiences (20). Specific events, although not inherently traumatic, can for some narcissistically fragile people take on an inner subjective traumatic meaning. Such narcissistic trauma threatens the individual's sense of continuity, coherence, stability, and well-being (21). Increased prevalence of PTSD (25.7%) has been found in patients with NPD (16), and NPD can predict development of PTSD (22). This is also consistent with findings of trauma (20) and fear (23) in NPD.

Identifying patients with pathological narcissism and NPD can sometimes be difficult. Some patients present with absence of symptoms or notable suffering while others report depression, substance use, mood swings, or eating disorder. Some patients effectively hide their narcissistic characteristics, and others are initially friendly and tuned in but gradually turn distant and aloof. Some present with malignant, antisocial, or psychopathic traits while others have high moral and ethical standards. Some are boastful, assertive, and arrogant, and others can be modest and unassuming with an air of grace; still others can present as perpetual failures, while constantly driven by unattainable, grandiose aims. One can be charming and friendly, another shy and quiet, yet another domineering, aggressive, and manipulative. Some are intrusive and controlling, others are evasive and avoidant. Some can openly and bluntly exhibit most extreme narcissistic features and strivings but still hide more significant narcissistic personality problems. While some can give well-informed and accurate accounts of their pathological narcissistic functioning, others may be totally oblivious of their problems and of why they seek treatment. Nevertheless, the common and underlying indications of narcissistic personality functioning include grandiosity and self-enhancement, vulnerability, and self-esteem fluctuations, limitations in interpersonal relationships, compromised empathic functioning and emotion recognition (24–26), and intense emotional reactions to threats to self-experience and sense of control.

Patients with pathological narcissism and NPD tend to evoke strong reaction in others, clinicians and therapists included. Awareness of countertransference (27) and attention to the clinician's own inclination to judge the patient and react critically, condescendingly, or with blame are important when helping these patients explore and understand the roots of their narcissistic functioning and to encourage their motivation and efforts to change.

Diagnosing NPD

There are several challenges involved in diagnosing patients with NPD. First, the diagnostic focus on patients' external characteristics tends to dismiss the importance of their internal distress and painful experiences of self-esteem fluctuations, self-criticism,

and emotional dysregulation. Consequently, clinical definition and usage of the NPD diagnosis also tend to differ significantly from the official criteria set. Second, the co-occurrence of NPD with acute major mental disorders and their predominant symptomatology, such as substance use, eating disorder, bipolar spectrum disorder, or atypical mood disorder, can complicate or diffuse the diagnostic identification of NPD (28, 29). Third, the protective and regulatory patterns in individuals with narcissistic pathology and NPD, such as avoidance and need for control, shame and denial, and limitations in ability for self-disclosure, self-awareness, and self-directed empathic capability and understanding, can easily lead to misinterpreting or bypassing significant NPD traits. Fourth, the actual narcissistic pattern or potential for developing a personality disorder may not be manifest in higher functioning people until they face a corrosive life event, a personal crisis or failure, or an acute onset of a major mental illness (19, 20). Fifth, a trait-focused diagnostic approach automatically tends to evoke defensive responses in narcissistic patients because it fails to reach a meaningful correspondence with their individual subjective correlates and experiences. Patients tend to oppose being "labeled" NPD, conceiving it as prejudicial and not informative.

A collaborative and exploratory diagnostic approach to pathological narcissism and NPD is highly recommended. The major task in alliance-building is to engage the patient and promote his/her curiosity, narration and self-reflection. Strategies that encourage integration of the patient's own accounts and understanding with the clinician's observations and knowledge can help bridge the often painful and inconceivable discrepancy between patient's own subjective experience and his/her interpersonal relating. Psychoeducation of the meaning and context of narcissistic traits and behavior can be an integral part of the initial evaluation. Integrating a dimensional self-regulatory understanding of pathological narcissism with diagnostically meaningful characteristics can help to identify the patient's fluctuating, variable, and fragile self-esteem and the co-occurrence of both grandiosity and inferiority. Such a diagnostic approach could identify and evaluate basic characteristics for narcissistic functioning, differentiate temporary fluctuating or externally triggered shifts from enduring indications of pathological narcissism, and acknowledge the narcissistic individual's internal emotional suffering related to insecurity, self-criticism, anxiety, shame, and fear.

Grandiosity is especially important to evaluate in the context of patients' self-esteem regulation (30). Central to pathological narcissism and NPD, grandiosity embraces both a sense of superiority and fantasies of self-fulfillment. It is related to perfectionism and high ideals, and the driving force behind self-enhancing and self-serving interpersonal behavior. Patients with NPD can have a range of dynamic, cognitive, emotional, and interpersonal ways to sustain and enhance grandiosity. Nevertheless, overt grandiosity is a state that is dependent and fluctuating and hence not a reliable diagnostic indicator of NPD (19). Narcissistic individuals are also extremely sensitive to criticism and failures as well as to self-directed aggression, self-doubts, shame, and fear. Subjectively perceived overwhelming failures or losses of self-esteem and grandiosity-sustaining conditions can lead to sudden, unexpected suicide (31).

COMORBIDITY OF NPD

AFFECTIVE DISORDERS

Major depressive disorder (MDD) is the most common comorbid disorder in NPD patients (45%–50%) (16, 28). Though lower NPD rates were reported in MDD patients (0%–16%) those patients with a mixture of depression, dysthymia or cyclothymia have a somewhat higher NPD prevalence (5%–11%) (28). Depression in MDD patients is typically precipitated by any life events that lead to disillusionment with self, self-depreciation, or loss of internal or external sustaining resources, e.g. failures, divorces, rejections, physical illness or injury, and aging. Depression in NPD, on the other hand, is likely to be characterized by anger (32) or transient quasi-paranoid thoughts (33), reactions consistent with an externalizing, self-protective orientation. Patients with dysthymia and NPD present with chronic boredom, emptiness, aloneness, stimulus hunger, dissatisfaction, and a sense of loss of meaning (34).

Bipolar disorders are present in 5%–11% of NPD patients, whereas about 0%–8% of euthymic bipolar patients meet criteria for NPD (28, 29). Hypomanic symptoms increase the likelihood of the incorrect NPD diagnosis. The important distinctive features of NPD versus hypomanic episode are the need for admiration, devaluation of others, and envy of others (35).

SUBSTANCE USE DISORDERS

Between 24%–64.2% of NPD patients meet criteria for any substance use disorders (SUD) (16, 28), making them among the most prevalent comorbid disorders in NPD patients. Prevalence of

NPD in samples of patients with alcohol abuse or dependence was 6%–7%, whereas it was much higher, 13%–38% in samples of patients who abused other substances (28). Several hypotheses can explain the association between NPD and SUD:

(i) both conditions stem from the same risk factors (i.e. trauma, genetic factors)
(ii) NPD leads to SUD
(iii) SUD leads to NPD (e.g., substance-induced personality or brain changes)

All these hypotheses have accumulated some support in studies of personality disorders in general (36), but have not yet been tested for NPD specifically.

Need for self-enhancement and chronic disillusionment with self make NPD patients particularly susceptible to substance use. Alcohol, benzodiazepines, opiates, and cannabis decrease disillusionment with self, whereas stimulants and cocaine create illusions of superiority, grandiosity, and self-sufficiency (37). For example, DSM Cluster B personality disorder patients report that they are more likely to drink excessively for reasons related to enhancement of positive mood and excitement-seeking (38), as seen in vignette #3.

VIGNETTE #3: "PIANO FOR FOUR HANDS ONE MORE TIME"

In his youth Mr. A, now an aging movie music composer, was spoiled by local recognition and success. Little was now left from his past grandeur: his job had come to a deadlock, his wife had died in a car accident, and his body was aging and weak. Oblivious to his collapsing life, he started drinking heavily to blur the distinction between sad reality and his idyllic memory of his past where he could be with his wife again and they could play the piano together. He came to treatment upon the urgings of his worried children.

Cocaine produces an expansive, grandiose sense of self, as well as an illusion of control and invulnerability. This makes cocaine a particularly apt choice for patients with NPD since it propels their vulnerable selves to a desired superiority (39, 40). Stimulants or cocaine may in fact increase performance and enjoyment of work, as well as prolong work hours, which may contribute to a faulty perception of those stimulants' benefits, thus making it challenging to give them up. Similarly, alcohol and other anxiolytics have the potential of alleviating academic and vocational stress, thus making some of the career-focused NPD patients, such as medical residents (41) and physicians (42), especially vulnerable as seen in vignette #4.

VIGNETTE #4: "SORROWS OF A VIRTUOSO SURGEON"

Dr. B, a medical resident, spent many hours dedicated to his career. Little did his family and colleagues know what he was hiding behind the external appearance of a promising, though slightly haughty trainee. Driven to become "the best", he developed a habit of drinking daily at work two to three bottles of wine to fend off anxiety about his evaluation. He felt that he must be "a real genius" if he could perform complicated surgeries while intoxicated. Thinking of himself as an exceptional human being, he believed that his drinking was excusable, if not commendable, that common rules did not apply to him, and that his surgeries were better and his scientific writing more innovative compared with that of others. When his wife noticed increased tremulousness and other withdrawal signs, she urged him to start treatment.

SUICIDE IN NPD

Prevalence of suicidal behaviors in NPD is not known. Research is limited to only a few empirical investigations and most available facts about suicide in NPD come from clinical studies as well as studies that focused on concepts related to NPD, not necessarily in NPD patients. The importance of this subject is hard to overestimate, inasmuch as, in our experience, suicidal behaviors are closely associated with NPD. This seemingly paradoxical association of suicide (i.e., self-destruction) and narcissism (i.e., self-expansion) reveals the complex nature of both conditions. One of the earliest depictions—that of the brave warrior Ajax who threw himself on his sword following a defeat—demonstrates such association.

Suicidal preoccupation in NPD has a number of unique characteristics, including the absence of depression, lack of communication, self-esteem dysregulation, and life events that decrease self-esteem (31, 43). Some people with pathological narcissism or NPD can have suicidal ideas and fantasies that actually serve a narcissistically protective self-regulatory function. Knowing that suicide is a possible option can sustain self-regulation and sense of control, and help such people stay connected, work and function, and even enjoy life. It is very important to differentiate between the life-threatening and life-sustaining implications of these patients' suicididal thoughts and fantasies (44).

COMORBID PSYCHIATRIC DISORDERS

Suicide risk in NPD patients escalates when NPD is comorbid with other psychiatric disorders. These

Table 2. Characteristics of Suicidal Behaviors in NPD in Absence of Major Mental Disorder

Loss of ideal self-state and the break-up of life dream
Not meeting high/perfectionist standards
Sudden defense breakdown
Turning revengeful wishes against oneself
Intolerance of passivity and assuming active role through suicidal action
Intolerance of humiliation, defeat, entrapment, shame, or envy

comorbid disorders interact with NPD dynamics in such way that they synergistically increase suicide risk. When MDD is present, suicidal dynamics are related to hopelessness, self-blame, anxiety, and other risk factors associated with suicide in MDD (45). In addition, depressive episodes are deeply shaming experiences for a patient with NPD who is likely to feel defeated and trapped by depressive experiences that are at odds with the usual grandiose sense of self and with expectations of functioning. Substance use can preserve grandiosity, yet it is likely to spur suicidal action through its detrimental effect on employment, quality of life, relationships, as well as exacerbation of other psychiatric disorders (46). Physical dependence is another humiliating experience of entrapment that is intolerable for patients with NPD who wish to remain free. Both panic disorder and eating disorders (especially anorexia nervosa) are associated with an increased suicide risk, although it is typically due to other comorbid disorders (47–49). Comorbid BPD is likely to increase suicide risk through a propensity for impulsive actions that cause havoc in interpersonal and professional lives, thus precipitating a sense of failure and defeat; emotional instability, associated with BPD, is humiliating for patients with NPD, who are invested in maintaining internal control (50).

Comorbid ASPD increases risk of suicide through either shame and defeat associated with the failure of psychopathic manipulations to accomplish a planned outcome; financial or interpersonal difficulties due to irresponsible, exploitative, or impulsive behaviors (51); a sense of helplessness when the person gets caught or incarcerated (52); and regret over misdeeds (53).

One of the unique characteristics of suicide in NPD is that suicidal dynamics can be present in the absence of other major mental disorders, particularly depression. This has been documented both empirically (54) and clinically (31, 43, 55) (Table 2).

PERSONALITY TRAITS

Some personality traits are closely associated with the risk of suicide in NPD (Table 3). Vulnerability of self-esteem, especially in response to life events that challenge habitual ways in which NPD patients sustain their lives, makes these patients particularly susceptible to suicide. Perceived failures and humiliations coupled with perfectionism increase feelings of shame, paralysis, and defeat, whereas inconsistent self-representation creates confusion, inner tension, meaninglessness, and lack of control. Consequently, the NPD patients feel besieged by shaming, perfectionistic standards, a sense of failure and defeat in their lives, while also being held back by a defective, weak body. They may feel too ashamed to seek support, thus increasing their desperation, and they are more likely to make planned suicides in which they try to preserve a sense of self-worth and escape their torturous prison.

LIFE EVENTS

Stressful life events are also closely associated with suicidal behaviors (75, 76), and certain life events are particularly pernicious for NPD patients:

(i) legal or disciplinary problems (75, 77)
(ii) unemployment (75)
(iii) physical illness (75)
(iv) financial problems (75)
(v) problems at school or job (77)
(vi) aging and aging-related losses and transitions (78)

These life events challenge narcissistic equilibrium by removing internal or external sources of self-esteem and thus lead to suicidal crisis.

EMOTIONAL STATES

Negative emotional states are the best short-term predictors of suicide. Narcissistic vulnerability creates susceptibility to feelings of shame, humiliation, defeat, entrapment, and meaninglessness which force them into a sense of desperation (79), thus leading to suicidal behaviors. Association between these feelings and suicide has been confirmed empirically (80–84).

CASE VIGNETTE #5: "BETTER DEAD THAN HUMILIATED"

Mr. C is a 45-year-old, unemployed architect who came to treatment following loss of his fiancée, who succumbed to cancer. His savings had dwindled in the

Table 3. Personality Characteristics of Suicidal NPD Patients

Trait	Suicidal dynamic
Perfectionism	(i) Related to high, unattainable standards that precipitate persistent sense of failure, of not being good enough, and relentless pursuit of elusive perfection (ii) Generates chronic feelings of failure, procrastination due to fear of mistakes, and ruthless self-shaming attacks, designed as punishment for perceived failures as well as misguided attempts to motivate better performance in the future (iii) Contributes to suicide risk (54, 56–59)
Lack of self-disclosure	Shame avoidance leads to self-disclosure deficits, interferes with help seeking, thus contributing to increased suicide risk (60)
Low impulsivity	In contrast to non-NPD suicide attempters, NPD attempters are less impulsive (61)
Dissociation	(i) Detachment from one's body (62, 63); body provides sense of being real and represents valued part of the self; dissociation eliminates these feelings, making suicide easier to carry out (ii) Cognitive deconstruction (64) – defensive avoidance of thinking in meaningful ways because of threats to self - increases propensity for destructive actions (65, 66) (iii) Inner deadness, commonly found in NPD patients (67) as well as in suicidal people (68) (i) - (iii) makes suicide more likely as an attempt to get rid of meaningless life and an already dead self
Body hatred	Expectations of Venus- or Apollo-like bodies or preoccupation with body imperfections (e.g. body dysmorphic disorder) lead to desire to get rid of imperfect body (43, 69)
Inconsistent self-representation	(i) Confused self-identity (70–72) (ii) Inconsistent standards of self, such as ideals and obligations (73) (iii) Propensity for self-disintegration (74) (i) - (iii) increase suicide risk

course of taking care of her until her last breath. His wealthy brother gave Mr. C an allowance and was paying his rent. Paralyzed by an agonizing fear of failure, Mr. C was procrastinating about his job search, spending months in aimless smoking, painting action figures, or in late-night bar visits. Avoidance preserved the illusion of superiority and a secret triumph of his competitive wishes vis-à-vis his brother. Frustrated by Mr. C's stagnation, his brother made the allowance conditional on performing some work. Plagued by procrastination, Mr. C was unable to fulfill his work duties and became preoccupied with fears of losing the allowance, becoming homeless, and living on the street. He contemplated killing himself, hoping to avoid humiliation and defeat through suicide. The crisis was relieved when he became more accepting of himself and took a less demanding job.

Treatment of NPD

People with pathological narcissism and NPD can seek treatment for various reasons and in different stages in life (Table 4). It is essential to handle the initial contact with narcissistic patients in ways that encourage their exploration of relevant problems and their willingness to address these problems in a meaningful way with the therapist. It is especially important to identify the patient's own understanding and description of problems and motivation to seek treatment, and several sessions may be required to reach such an agreement. A flexible treatment approach, adjusted to the individual patient's functioning, motivation and degree of self-awareness, is strongly recommended, as is a respectful, consistent, attentive, and task-focused therapeutic attitude (30, 85).

Alliance building with a narcissistic patient is a slow and gradual process. A central task is to balance the patient's avoidance and sudden urges to reject the therapist and drop out of treatment with the goal of encouraging and enabling the patient to face and reflect upon their experiences and behavior. In addition, there are a number of common mistakes in treatments of NPD patients:

(i) directly confronting or criticizing grandiosity
(ii) over-attending to the patient's grandiosity by ignoring insecurity, vulnerability and failures, as well as real personal capabilities and assets
(iii) engaging in competitive, controlling relationship with the patient
(iv) taking a passive approach, expecting the patient will generate necessary solutions and progress without external help.

Awareness of these pitfalls can help to avoid impasses or early treatment terminations.

Several treatment approaches are specifically adjusted to pathological narcissism and NPD (Table 5),

Table 4. Patients With NPD in Treatment

Reasons for Seeking Treatment	Problems, Complaints, and Symptoms	Personal Functioning and Life Circumstances
Ultimatum or requirements from family, employers, or courts	Denial or lack of awareness of own problems or suffering; unassuming naiveté; projection or blame of problems onto others	Consistent self-enhancing or narcissistically sustained functioning; fluctuations in vocational/professional performance or in collaborative or interpersonal/intimate functioning
Dissatisfaction with life; unable to reach or pursue goals or aspired accomplishments	Absence of major external problems; inner emptiness, meaninglessness, dysphoria, inability to form or maintain close relationships, social isolation; facing limitations or inability to reach goals in personal or professional life	Consistent or high-functioning with self-regulatory sustaining interpersonal and/or vocational ability, areas of success, or recognition; internal doubts, self-criticism, distancing, and detachment
Acute crises; vocational, financial, or personal failures or losses	Rage outbursts, sexual dysfunction, situational anxiety, insecurity, inferiority, shame, fear	Sudden or gradually developing corrosive life circumstances
Mental disorder; acute or gradual onset of bipolar disorder, substance abuse, PTSD, or major depression	Depression, anxiety, rage or mood lability, growing dependency on alcohol or drugs, sudden memory flashbacks, or intrusive thoughts	Self-enhancing function of mood elevation or substance use; reoccurrence of narcissistic trauma; sudden or gradual functional decline
Suicidality; acute serious suicidal preoccupation; having survived a lethally intended suicidal effort	Internal despair, fear, overwhelming shame and humiliation, worthlessness, rage	Job loss, financial crises, failed promotion, divorce, loss of significant sustaining attachment or self-regulatory support; other subjectively traumatic or severely humiliating experiences

but so far no single treatment strategy has proven superior or reliable. Psychoanalytic and psychodynamic therapy are the most common (86–96). Transference-focused therapy, which applies an active and interactive approach with exploration and interpretation, has recently proven beneficial (97, 98). Within the cognitive realm, schema-focused therapy (99, 100) and metacognitive interpersonal therapy (101) are modalities developed specifically for NPD, while DBT (102), originally developed for treatment of BPD, can be useful for some patients who are motivated to learn skills for improving control, self-regulation, and agency. Psychoeducation can promote patients' understanding of their emotional and intrapsychic experiences, diminish fear of the unknown and uncontrollable, and in a similar way help strengthen their sense of internal control and agency. Mentalization-based treatment (103) can be helpful for high achieving professional people in crises as it focuses on self-regulation and awareness of mental states in others. Similarly, group therapy (104, 105) and couples therapy (106, 107) can for some people be of use, foremost depending upon their personality functioning and life circumstances (Table 5). Psychopharmacological treatment can be beneficial for treating excessive aggressivity, or comorbid mental disorders, such as bipolar disorder, major depression or substance usage disorder. However, narcissistic patients' hypersensitivity to side effects, especially those affecting sexual and intellectual functioning, call for extra caution. No specific pharmacotherapy has proved to be effective for pathological narcissism and NPD.

When people with NPD come to treatment because of a major mental disorder, such as depression, dysthymic disorder, or substance use, case formulation and treatment planning should emphasize the centrality of NPD. As mentioned above, patients are not likely to welcome discussion of the NPD diagnosis, which can make them feel controlled or ashamed. However, experience near discussion of the patient's difficulty to maintain stable self-esteem in experience near terms is likely to help in alliance-building and collaborative treatment planning.

Comorbid disorders need to be recognized and included in treatment. Depression usually improves when the underlying narcissistic vulnerability resolves. Medications are typically only modestly helpful in addressing depression in NPD. Further, when depression improves due to resolution of the precipitating conditions (e.g., finding a new job, new partner, healing of physical injuries), the patient may lose motivation for further treatment. Such premature terminations may be avoided if the patient understands that the resolution of underlying vulnerability is important in preventing future depressions. Such explanation is helpful at the early stage of

therapy relationship, when the patient and the therapist agree to address not only the mental disorders, but also the identified personal vulnerability, e.g. vulnerable self-esteem, perfectionism, shyness, etc. Addressing substance use is critical for success of the treatment, insofar as active substance use precludes successful utilization of therapy and makes many patients with NPD untreatable (see case vignette #6). Integrative treatments are needed that address both NPD and the comorbid substance use disorder (108), although research in this area is lacking. Targeting both conditions is critical for successful treatment of either of them.

Table 5. Treatment Modalities

Specifically for NPD	Specifically for BPD Applied to NPD
Psychoanalysis	Dialectical behavioral therapy (DBT)
Psychoanalytic psychotherapy	Mentalization-based therapy
Psychodynamic psychotherapy	
Transference-focused psychotherapy (TFP)	
Schema-focused therapy (SFT)	
Metacognitive interpersonal therapy (MIT)	
Group therapy	
Couples therapy	

CASE VIGNETTE #6: "YOU WANT THE BEST, YOU GOT THE BEST?"

Mr. D, an administrative assistant employed by his father in the family business, wanted the best for himself: the best job, the best romantic relationship, and the best car. Fluent in administrative language, he concocted a term for his position that made it sound unique and lucrative, though his performance was unreliable, and he maintained his job because of the "good heart" of his father. He dated a few women, whom he wished to view as a perfect extension of himself, and he would typically dismiss them if they were disliked by his family or if they disagreed with him. Cocaine proved to be more reliable in producing elation, a sense of well-being, and grandiose self-perception. Through a series of ultimatums by his family, he was finally urged to come to treatment. He demanded "the best room" in the treatment facility, "the best therapist," whom he immediately requested to change, and offered to hire a personal psychiatrist for himself whose salary he "generously" offered to pay. Quoting his desire for the "best treatment," he continued to order his treatment team around, avoiding exploring his own problems. Scared to focus on himself, he asked for an early discharge and dismissed the recommended after-care, only to be found intoxicated 48 hours later.

The expected outcome in treatment of NPD varies and is dependent upon a number of factors: treatment modality and focus, the patient's motivation and ability to establish and sustain an alliance with the treatment provider, type of identified and processed problems, and external life circumstances that either support or intervene with treatment. We would like to highlight five general areas of change that are central to pathological narcissism and NPD:

1. **Interpersonal and vocational functioning**. Ability to accept and maintain real relationships and/or consistent vocational functioning; ability to negotiate and collaborate; assessment and modification of self-serving and self-enhancing strivings and behavior; increased ability to modulate reactivity, self-serving manipulations and enactment.
2. **Sense of agency.** Improved ability to maintain self-direction with less fear of losing competence and internal control; tolerance of criticism, failures and defeat, with ownership of actual competence and potentials; apply proactive self-evaluation and assessment.
3. **Emotion regulation.** Increased ability to understand, tolerate and modulate feelings, especially anger/rage, shame and envy; decrease automatic secondary feelings (feelings vis-à-vis feelings, e.g. anger when feeling ashamed, or self-hatred when feeling insecure); tolerance of insecurity and inferiority; reduced excessive self-criticism and paralyzing self-hatred.
4. **Reflective ability.** Tolerance of and ability to modulate variable self-states and fluctuations in self-esteem; ability to identify diffuse or complex, often embarrassing and shameful internal experiences; identify own and others' perspectives, as well as perceptions of the impact of contextual circumstances; coherent and meaningful narratives of internal and external experiences.
5. **Ability to mourn.** Processing of losses of wished for and unreachable internal self-states, relationships and other ideal external conditions; acceptance and surrender of unattainable goals and aspirations; recognition and ownership of what indeed is attainable, manageable, and available, of own real capability and relativeness; access of consideration and responsibility.

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