REVIEW

Narcissistic Personality Disorder: Progress in Understanding and Treatment

Igor Weinberg, Ph.D., and Elsa Ronningstam, Ph.D.

This review summarizes current knowledge about narcissistic personality disorder (NPD). Each section brings the reader up to date on advances in our knowledge during the last decade. In terms of NPD diagnosis, this review describes the addition of the dimensional model to the categorical model. The accumulating knowledge has led to the description of grandiose and vulnerable narcissism as well as their complex interrelationship. Strong support exists for co-occurrence of these presentations among people with high levels of grandiose narcissism. Studies have identified mechanisms, in domains such as self-esteem dysregulation, emotion dysregulation, cognitive style, interpersonal relations, and empathy, and possible developmental and temperamental antecedents of the disorder. Thus, it appears that NPD has a multifactorial etiology and pathogenesis, with numerous mechanisms associated with each area of dysfunction. Longitudinal studies support the view that these patients can improve, but such improvement is gradual and slow. Several treatments have been developed for the disorder, and a majority share commonalities, including clear goals, attention to treatment frame, attention to relationships and self-esteem, alliance building, and monitoring of countertransference.

Focus 2022; 20:368–377; doi: 10.1176/appi.focus.20220052

Narcissistic personality disorder (NPD) is defined in the *DSM-5-TR* (1) in terms of a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, with onset by early adulthood and present in a variety of contexts. The disorder is found in 1%–2% of the general population, 1.3%–20% of the clinical population, and 8.5%–20% of the outpatient private practice population (2). It is associated with increased risk and persistence of comorbid conditions—mood and anxiety disorders; alcohol and substance use disorders; suicide; and legal, vocational, relational, and marital problems (3). People diagnosed as having NPD experience elevated distress (4), cause more pain to others (5), and have a lower quality of life (6) than those without the disorder. Pathological narcissism is defined as pervasive and consistent difficulty maintaining realistic self-esteem that, at its extreme, manifests as NPD (7).

In this article, we review advances in understanding and treatment of NPD during the past decade. We discuss changes in diagnostic approach, various manifestations and mechanisms of the disorder, developmental factors, naturalistic longitudinal course, and treatment strategies.

NPD: CATEGORICAL VERSUS DIMENSIONAL DIAGNOSIS

Historically, NPD has been defined in the *DSM*, including the *DSM-5*, through a list of nine nomothetic criteria that capture grandiose narcissism. Fulfilling five out of nine criteria is a cutoff score for meeting inclusion criteria. This categorical approach makes clear who meets the criteria for the disorder and who does not, and it maintains continuity with the previous literature on the disorder and its treatment. However, this criteria-based definition has been criticized as too narrow (8); at the same time, the categorical diagnosis of personality has been criticized as well (9). These concerns have paved the way for development of the dimensional model of diagnosis (10).

The dimensional model emphasizes four areas of functioning organized into two dimensions each—self (identity, self-direction) and interpersonal relations (empathy, intimacy), as well as two personality traits (grandiosity and attention seeking), which represent antagonism (Box 1). The dimensional approach has the following strengths: it provides clinically meaningful description of the patient's individual personality patterns, subjective motivation, and experiences (11, 12); attends to fluctuations and range of phenotypic presentations; incorporates sense of self-agency (i.e., competence, decision making, motivation, and sense of control [internal and external]); and emphasizes a complex interaction among various capabilities, deficits, motivations, self-regulation, and self-enhancement in coloring expressions of self and interpersonal domains. This approach guides clinicians to assess the disorder and to remain open-minded to the complex and fluctuating manifestations of this disorder. The approach also suggests

BOX 1. Diagnosis of narcissistic personality disorder via the *DSM-5* Alternative Model for Personality Disorders[a]

***DSM-5-TR* Section III Diagnostic Criteria**

Identity

Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal may be inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem.

Self-Direction

Goal-setting is based on gaining approval from others; personal standards are unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.

Empathy

Impaired ability to recognize or identify with the feelings and needs of others; excessively attuned to reactions of others, but only if perceived as relevant to self; over- or underestimation of own effect on others.

Intimacy

Relationships largely superficial and exist to serve self-esteem regulation; mutuality constrained by little genuine interest in others' experiences and predominance of a need for personal gain.

Both of the Following Pathological Personality Traits

Grandiosity (An Aspect of Antagonism)

Feelings of entitlement, either overt or covert; self-centeredness; firmly holding to the belief that one is better than others; condescending toward others.

Attention Seeking (An Aspect of Antagonism)

Excessive attempts to attract and be the focus of the attention of others; admiration seeking.

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exploring various aspects of patient functioning, which are likely to be hidden by the patient or not mentioned if the assessment relies exclusively on unguided patient self-report.

Both the *DSM-5* (Section III) (1) and the *ICD-11* (13) recommend using a hybrid model of diagnosis, which combines the categorical and dimensional models, because this combination has the strongest predictive validity (9, 14). The following vignette shows the complex interaction of an other-oriented sense of identity in the context of different experiences of self and others. Fluctuations in self-esteem with significant self-negativity are associated with difficulties tolerating and integrating emotions as well as with ambivalence toward one's own aspirations and others' ideal expectations.

> Mr. A is a 25-year-old college graduate who worked as an office assistant in a law firm. He was recommended psychotherapy by his supervisor as he had begun smoking cannabis and avoiding exposure and challenges at work. He had been a competent basketball player for his college team. After graduation, he was forced to leave his team and, thus, struggled with emptiness and identity confusion. He felt lost and stuck in life, ashamed of his job, and, perceiving himself as a failure, unable and unmotivated to pursue education toward a law career. His biological father was an industrial worker and a devoted dog owner, whereas his stepfather, who came into his life when he was 5 years old, was a professor in law with international accomplishments. Although he loved his biological father and enjoyed playing with his dogs, Mr. A felt repelled by his father's lifestyle and lack of ambitions. On the other hand, although the stepfather's extraordinary recognition and competence intrigued and benefited him, Mr. A felt threatened and diminished by his presence. He was also aware that his stepfather had provided a significantly different lifestyle, with opportunities and security. He felt he put on different faces and facades in different situations to avoid conflicts and expectations, but also to gain approval. He also felt that he did not deserve to pursue a continuing basketball career. Further exploration in psychotherapy revealed Mr. A's anger and disappointment at both of his fathers, as well as his deep shame thereof. In addition, he struggled with distrust and a lack of reliable support from his mother, whom he felt was critical and demanding, perceiving him as unable to measure up to the changed sociocultural values and economic standards in the new family.

SUBTYPES OF NPD

Complexity in the clinical presentation of NPD has spurred description of different characterological types of the disorder. Are these different manifestations of the disorder or do they constitute different personality types? Since the beginning, the research literature has highlighted the multifaceted nature of pathological narcissism. Early emphasis on the grandiose presentation gave way to recognition of two types of narcissism: grandiose and vulnerable (15, 16). This categorization remains consistent with the criticism of the construct of grandiose narcissism as being too restrictive (17). Compared with the general population, people with grandiose narcissism appear as bold and charming, although they are more disagreeable, engage in more social comparison, feel more envy, are more extraverted, more likely to pursue status, and have higher reported self-esteem (18, 19). People with vulnerable narcissism are more introverted, anxious, and avoidant, but they are disagreeable and less conscientious, and they report more anger, shame, and depression, as well as higher hostility and/or aggression and lower self-esteem, trust, and relationship satisfaction (18, 19). Both manifestations are characterized by entitlement—a belief that one is deserving of special benefits and attention

(7). The presence of this belief proves important for the differential diagnosis of the vulnerable manifestation from other conditions, such as mood or anxiety disorders. Initially, both presentations were considered separate types of pathological narcissism that occurred among different people. Over time, clinical experience and documented research have proven that these two presentations tend to co-occur.

It appears that when levels of vulnerable or grandiose narcissism are low to moderate, these two dimensions are independent. However, grandiose and vulnerable narcissism tend to co-occur within the same patient when high levels of grandiosity are present (19). More specifically, people who are grandiose tend to express both grandiose and vulnerable facets, whereas people who are vulnerable tend to present with high vulnerability and low grandiosity (20).

Vulnerable narcissism is also associated with impaired optimism and future orientation, noticeable in diminished sense of agency and strivings toward personal growth (21). The distinction between chronic depression in depressive personality disorder and vulnerable narcissism is important because both are often associated with similar qualities (22). However, entitlement, assertiveness, overvaluing one's own accomplishments, and aggressive reactions when aspirations fail or remain unrecognized are distinguishing features accompanying self-negativity and depressivity in vulnerable narcissism.

The co-occurrence of grandiose and vulnerable narcissism expresses itself in numerous ways. Some patients alternate between grandiose and vulnerable presentation in different sessions (23):

> When Mr. B started therapy, he described himself in a confident and haughty way. He self-identified as arrogant and very competitive, dreaming of making the "30 under 30 list" with his newly launched start-up company. Two sessions later, he described a paralyzing sense of insecurity, shame, and rejection sensitivity in his romantic relationship. He worried that his partner might break up with him because of his almost invisible hair loss, "a possibility" that he does not make enough money, and a worry that he will run out of jokes to make her laugh.

Other patients display an intermixture of vulnerable and grandiose traits concurrently. This presentation creates a paradoxical coexistence of seemingly contradictory traits and modes of operating and relating:

> Ms. C started treatment in the context of pervasive insecurity about social interactions. She described difficulty initiating conversations because of fear of rejection and feelings of shame, combined with a tendency to be easily offended and an expectation to be automatically accepted by others. After a few months of treatment, she described a deep-seated tendency to judge herself and others and to think of others as "incompetent and stupid." She wanted to feel better than others and frequently fantasized about becoming a world-famous artist, thus "proving to be better than others."

Interpersonally, many patients with pathological narcissism, including NPD, are capable of a fluid adaptability, guided by impression management. This adaptability creates a chameleon-like clinical presentation accompanied by a theatrical, performative, and disingenuous atmosphere. Subjectively, the patient frantically attempts to mask personal limitations, make a "perfect" impression, and create an "ideal" connection. For some patients, this attempt leads to a haughty, grandiose presentation; for others, paradoxically, a vulnerable one. The latter scenario is more likely to occur when the patient invests in a narrative of helpless, agentless victim, or is afraid of expectations of change. In this way, the patient tries to lower the interviewer's expectations.

Another form of fluidity has to do with the intrapsychic tendency to shift from one personal narrative to another to protect a sense of specialness and superiority (24, 25). Similar to kings of the Assyrian Empire, patients re-tell their own history in order to erase failures, disappointments, or embarrassments, and to glorify their sense of specialness. Others are invested in perpetuating the opposite narrative to minimize expectations and, thus, shield themselves from anticipated failure (26). Paradoxically, dysphoria has a protective effect on self-esteem for patients invested in negative predicaments.

An additional dimension of pathological narcissism is overt versus covert expression. The overt expression corresponds to the prototypical manifestations of grandiose or vulnerable narcissism. However, in some patients these manifestations become suppressed, dissociated, or kept secret (27). As a result, patients experience their conscious self as bad, weak, inadequate, or shameful. Difficulties with intimacy are prevalent and so is the tendency to rely on interpersonal distancing, to the point of aloofness. This aloofness shields them from disappointments, rejections, and challenges to self-esteem. Clinically, although these patients may present with a wide variety of symptoms, overall, they display a pervasive difficulty maintaining self-esteem. Consequently, they tend to have strong internal reactions to disappointments, rejections, or challenges to self-esteem, which they then tend to dissociate and deny. Sometimes the covert presentation occurs because of a history of being humiliated, shamed, or criticized for overt expression of narcissistic experiences and needs (27). The overt versus covert dimension is independent of the vulnerability versus grandiose dimension (11, 28), although unlike the latter, it is relatively invariable over time and across domains. Some patients show a mixture of overt and covert features in different domains (28).

These characteristics invite clinicians to take an open-minded, longitudinal, and careful approach to assessment, while considering multiple sources of information and paying attention to verbal and nonverbal reactions as well as to their own reactions to the patient.

MECHANISMS OF NPD

The complexity of subtypes and manifestations of pathological narcissism, including NPD, is likely related to the

complex interplay of the psychological mechanisms of this disorder. Mechanisms refer to underpinnings of the disorder that are related to and are responsible for the symptoms and functioning associated with the disorder (29). Study of mechanisms is important for the understanding of NPD and in developing effective treatments that target these putative mechanisms.

Self-Esteem Dysregulation

NPD is considered a disorder of self-esteem dysregulation. However, it remains unclear what constitutes the essence of such self-esteem dysregulation: is it the use of maladaptive self-esteem regulatory strategies (e.g., compensation) to upregulate low self-esteem, a lack of integration between beliefs related to low self-esteem versus high self-esteem, or is the self-esteem dysregulation a result of emotional dysregulation? Research supports a multifaceted nature of self-esteem dysregulation in NPD, so that these processes work synergistically. The disorder is associated with low explicit self-esteem; whereas, in patients with higher severity, there is both low explicit and high implicit self-esteem, indicating less integration (30). Emotional states, such as envy or shame, affect self-esteem (31, 32), and self-esteem regulation and emotion regulation mutually affect each other in numerous ways (33).

Emotional Dysregulation

NPD is associated with a combination of difficulty recognizing emotional facial expressions, especially fear and disgust (34), along with hypervigilance toward negative and neutral emotions and a propensity to react with anger (35). It is also associated with elevated fear and avoidance (36) and a propensity to react with anger out of shame (37). Grandiose narcissism is selectively related to angry reactions in response to threats of failure, but not rejection, whereas people with vulnerable narcissism react with anger to threats of rejection, but not failure (38).

Cognitive Style

NPD is associated with avoidant and dismissive cognitive processing (39), increased risk taking (40), difficulty learning from mistakes (40), self-serving attributional bias irrespective of one's performance (Krusemark, 2009, unpublished dissertation), and the use of language for self-regulation and not for communication (39). These features are partially independent of other areas of functioning and constitute trait-characteristics of cognitive functioning. Clinically, these findings highlight difficulty learning from experience. This difficulty is an important barrier to treatment.

Interpersonal Style

NPD is associated with dominance, vindictiveness, and intrusiveness (41). Relatives of people diagnosed with the disorder report increased distress and frustrated dependency striving (5, 42). Grandiose narcissism is associated with the triad of admiration-seeking, rivalry, and retaliation (43, 44) and a propensity to act in a quarrelsome manner when others are seen as dominant (45). Studies (46, 47) have documented preoccupied, dismissive, or not-possible-to-classify attachment patterns, implicating representations of self and others as underpinnings of the disorder and the associated interpersonal style. Emotional experiences affect interpersonal functioning, because among people with vulnerable narcissism, shame tends to color perception of self and others in a more negative light (48).

Empathy

Problems with empathy have long been considered a central feature of the disorder. In the *DSM*, the diagnostic criteria have primarily indicated a lack of empathy, although the causes have varied. When NPD was introduced in the *DSM-III*, empathy in NPD was assigned as an inability to recognize and experience how others feel. In the revised *DSM-IV-TR* and *DSM-5*, it was changed to an unwillingness to recognize and identify with the feelings of others, and, finally, in the *DSM-5*, Section III, the Alternative Model for Personality Disorders (1), empathy in NPD was defined as an impaired ability to recognize or identify with the feelings and needs of others.

This gradual change in definition is consistent with burgeoning empirical findings on empathy and its neurological and neuropsychological underpinnings. NPD is associated with neurophysiological deficits in emotional empathy, together with intact cognitive empathy, and influenced by a complex interaction between motivational, self-regulatory, and interpersonal processes (e.g., engagement versus disengagement), as well as by emotional dysregulation and intolerance (49–52). This change in definition invites the clinician to consider alternatives to the patient's inability to engage empathically, such as consciously deciding not to attend to others, disengaging from others because of emotional intolerance, disengaging from others because of self-regulatory processing issues or lack of interest, co-occurrence of feelings and intolerance thereof, as well as conflicting interests and experiences. In addition, caring actions can be motivated by envisioned advantages or interpersonal gains, without accompanying emotional empathic engagement. This complexity in empathic functioning necessitates new approaches in assessment and treatment. It is important to invite patients to become aware of and able to describe their subjective experiences and personal challenges in interpersonal interactions and to help them attend to self-understanding and ability to make changes in their empathic engagement.

To conclude, NPD is associated with specific difficulties related to self-esteem regulation, emotion regulation, cognitive processing, interpersonal style, and empathy. Although these areas are partially independent of each other, they reciprocally influence each other. This reciprocal influence requires clinicians to attend to all areas of functioning and to their interdependence. In treatment, it is essential to address all these areas as well as their complex interrelationships.

DEVELOPMENTAL FACTORS IN THE ETIOLOGY OF NPD

One way to understand the multiplicity of the mechanisms is through the complexity of the developmental trajectories that lead to the development of pathological narcissism, including NPD. Early clinical observations attributed development of the disorder to single developmental factors, such overvaluation and lack of warmth, overindulgence and lenient discipline, role reversals with parents (parentification), molding the child according to parental wishes, childhood abuse, cold and rejecting parenting, and unavailable parents (53).

Second-generation studies have relied on large samples, structured assessments, and mostly retrospective design to identify childhood antecedents of narcissism primarily among nonclinical samples, while focusing on single developmental factors. The third generation of studies has examined multiple factors concurrently. Those studies have documented differential etiologies for vulnerable versus grandiose narcissism and a multifactorial etiology of NPD. Table 1 documents second- and third-generation studies (54–70).

Prospective studies (71, 72) have identified temperamental characteristics, such as interpersonal antagonism, impulsivity, attention seeking, high activity level, histrionic tendencies, and low playfulness as childhood antecedents of grandiose narcissism. Vulnerable narcissism has been prospectively predicted by childhood impulsivity and unstable self-esteem (72). Parental monitoring was found to protect against development of narcissistic traits in a prospective study (59).

Parent-infant observational studies have highlighted putative, although untested, interactional patterns, such as lack of synchrony in emotional interactions (73) and propensity for noncontingent marked mirroring of emotional experiences of the child (74). We hope future studies will examine these possible antecedents in NPD etiology.

> Mr. D came to treatment due to a paralysis in his career. He accepted a tenured position but found himself stuck in a perpetual cycle of procrastination and self-criticism that reduced his productivity to a dangerous low. He was ambitious and dreamt of effortlessly making groundbreaking research contributions. In treatment, he reported that his parents used to praise him unconditionally: "Everything I was doing was excellent; even when I was failing at school! I learned that no matter what I did, I was great. The word 'success' became meaningless to me, and I did not care to work or study hard." Mr. D realized a close connection between his upbringing, his fantasies of effortless success, and work paralysis and started putting in effort at work.

Consistent with empirical findings of multiple developmental trajectories of maladaptive perfectionism (75), clinical experience has shown multiple developmental trajectories of pathological narcissism, including NPD as an adaptation to neglectful parenting (emotional neglect, lack of warmth, rejection, childhood maltreatment) through overreliance on self; as an effort to protect unrealistic self-esteem (overvaluation by parents, lenient discipline, overprotective parenting) against disappointment; and as a compensation for humiliating and abusive interactions (emotional, physical, or sexual abuse and/or parental criticism).

Thus, many roads may lead to the development of NPD, and patients with similar clinical presentations may have differing developmental antecedents. This aspect highlights the importance of an open-minded exploration of a patient's history, because making assumptions about childhood development is likely to repeat the cycle of misunderstanding.

LONGITUDINAL COURSE

With numerous factors contributing to development of pathological narcissism, including NPD, one could expect a slow process of change. Overall, studies (Table 2) (76–83) have documented the persistence of narcissistic pathology, even among patients who improve symptomatically. Patients with the disorder tend to improve slowly and gradually, and rapid improvements have not been documented (84). Studies that have used categorical diagnosis of the disorder have tended to document symptomatic improvements, whereas studies that have relied on dimensional measures of pathological narcissism have tended to demonstrate stability of the disorder. A likely explanation of the disparity between the outcomes for categorical versus dimensional diagnosis has to do with the persistence of core narcissistic issues as well as of comorbid personality disorders (84, 85). These comorbid conditions are likely contributors to the persistence of functional impairment (i.e., unrelenting challenges in interpersonal functioning, especially in the romantic arena) (76). Age (80–82) is a likely moderator of outcome, as younger samples have shown slightly more improvement (82). Life events, such as achievements, new relationships, and disillusionments, when processed in a sympathetic environment, allow some patients to learn from these experiences and to improve symptomatically (79). On the other hand, paranoid thinking, antisocial traits, and ego-syntonic aggression impede improvement (86). Effects of other likely moderators, such as history of adversity, employment, or interpersonal functioning, have not been tested. Taken together, these findings are consistent with the clinical observations that changes are possible, albeit slow and gradual.

TREATMENT OF NPD

One moderator of the longitudinal course of NPD is treatment. Can treatment lead to significant change, and what treatment strategies seem to work? To date, no form of psychotherapy or pharmacotherapy has been tested empirically in randomized controlled trials. Treatments for patients with this disorder are challenging. When samples of patients with the disorder have been followed, categorical diagnosis of narcissistic personality disorder has been

TABLE 1. Developmental factors in the etiology of narcissistic personality disorder

Factor	Grandiose narcissism	Vulnerable narcissism	Studies
Childhood adversity	Emotional abuse		Clemens et al., 2022 (54)
	Physical abuse	Physical abuse	Cohen et al., 2014 (55): Keene and Epps, 2016 (56)
	Physical neglect		Hengartner et al., 2013 (57)
	Verbal abuse		Johnson et al., 2001 (58)
	Parental hostility		Wetzel and Robins, 2016 (59)
	Maltreatment	Maltreatment	Bertele et al, 2022 (60)
Parenting styles	Parental overvaluation		Brummelman et al., 2015 (61)
	Paternal lenient discipline and overvaluation	Maternal lenient discipline; permissiveness, overindulgence	Van Schie, 2020 (62)
	Invalidation	Invalidation	Huxley and Bizumic, 2017 (63)
	Lack of warmth; coldness, rejection	Coldness, rejection	Horton et al., 2006 (64); Otway and Vignoles, 2006 (65); Watson et al., 1995 (66); for opposite findings, see Horton and Tritch, 2014 (67)
	Parental control		Horton et al., 2006 (64); Horton and Tritch, 2014 (67); Winner and Nicholson, 2018 (68)
	Overprotection	Overprotection	Brummelman et al., 2015 (61), Winner and Nicholson, 2018 (68); Segrin et al., 2013 (69); Segrin et al., 2012 (70)
Attachment style	Dismissive		Diamond et al., 2014 (46)
	Avoidant		Diamond et al., 2014 (46)
	Not possible to classify		Diamond et al., 2014 (46)
		Preoccupied	Cramer, 2019 (47)
		Fearful	Cramer, 2019 (47)

TABLE 2. Naturalistic course of narcissistic personality disorder

Study	Age	Gender (male %: female %)	Design/N	Length (years)	Outcome
Plakun, 1989 (76)	Mean=24.5, SD=7.7	48:52	Retrospective/17	13.6	Poor functioning, poor romantic relationships
McGlashan and Neinssen, 1989 (77)	16–55	42:58	Retrospective/12	15	Improvement similar to borderline personality disorder, more co-occurring alcohol use disorder, suicidality
Stone, 1989 (78)	13–39	71:29	Retrospective/20	16	Improvement similar to borderline personality disorder; NPD+antisocial personality disorder worse overall outcome
Ronningstam et al., 1995 (79)	22–45	85:15	Prospective/20	3	NPD categorical diagnosis: Reduction in NPD by 60%
Vater et al., 2014 (80)	Mean=34.8, SD=10.15	42.5:57.5	Prospective/40	2	NPD categorical diagnosis: 53% remission rate; NPD dimensional diagnosis: stable course
Durbin and Klein, 2006 (81)	18–60	27.5:72.5	Prospective/142	10	NPD dimensional diagnosis: stable course
Hopwood et al., 2013 (82)	18–45	38:62	Prospective/266	10	NPD dimensional diagnosis: 24% stability
Lenzenweger, 1999 (83)	18–22	53:47	Prospective/258	3	NPD dimensional diagnosis: 46%–64% stability

associated with a 63%–64% drop-out rate from psychotherapy (87, 88), and the presence of elevated dimensional measures of pathological narcissism predicted an increased drop-out rate (89). Factors, such as dismissive attachment, perfectionism, shame, and devaluation, have tended to predict worse outcome (90–93). Patients diagnosed with NPD tend to provoke powerful feelings in their therapist (94), and these feelings, if unprocessed, often contribute to stalemates. Another frequent challenge is "nontreatment treatments"—therapies that continue despite lack of change. Typically, such nontreatment treatments take place because of a lack of clear, realistic, and measurable goals; a pervasive pattern of devaluation of treatment, competitiveness, or envy in the relationship with the therapist; or a persistent pattern of idealization, extreme therapist-pleasing behaviors, and a pattern of mutual idealization by the patient and the

BOX 2. Principles of effective therapies for narcissistic personality disorder and others

- Set realistic goals
- Attend to treatment frame
- Attend to relationships and self-esteem
- Build alliance
- Monitor countertransference

therapist. Patients who remain in therapy typically show slow, gradual changes, although therapeutic gains are less likely. These factors make development and validation of effective treatments for NPD an important priority.

A few pre-post studies have documented clinically significant change, including symptom reduction and improved functioning among patients (95–97) (Weinberg et al., 2019, unpublished manuscript), providing hope that treatments can make a difference. Box 2 summarizes common principles in effective therapies.

How do treatments work? Motivation for coming to treatment appears to be influenced by numerous factors, such as ultimatums from work, family, or friends; dissatisfaction with life or inability to accomplish important goals; acute life crisis; worsening of another comorbid condition; and suicidality (3). It is important to explore these motivations and to help the patient transform situational motivation into a commitment to long-term therapy.

At the outset of treatment, it is important to discuss diagnostic impressions regarding NPD with the patient (2, 98, 99). Some patients welcome such diagnostic disclosure, whereas others experience it as a shameful label. This reaction requires sensitivity and flexibility from the clinician, who should consider discussing the diagnosis in experience-near terms without necessarily using the diagnostic label. Diagnostic disclosure anchors the treatment, aids in defining treatment goals and treatment-interfering behaviors, and helps create a longer treatment commitment. Psychoeducation helps prioritize treatment, especially when patients have comorbid disorders.

Identifying and working toward realistic goals that the patient wants to attain safe-guards against nontreatment treatment and anchors the treatment in reality. This work helps the patient develop a sense of agency, face and challenge self-defeating patterns (e.g., getting angry or paralyzed when disappointed), and develop a more functional approach to management of self-esteem and unavoidable life challenges.

Negotiation of the treatment frame addresses expectations regarding treatment (e.g., change does not happen instantly) and respective patient-therapist roles (e.g., therapist is not available around the clock). Anticipating treatment-interfering behaviors (e.g., how to handle dishonesty, substance use) may protect against early terminations or ineffective treatments.

Treatment entails close collaboration with the patient and attention to the complex and constantly changing clinical presentation. One aspect of treatment is gaining awareness of these dynamics and understanding the factors that affect the patient (e.g., feeling humiliated when evaluated). This awareness helps patients to develop a more coherent narrative about themselves (2). However, attention to what patients with the disorder do is usually at least as important as what they say. This attention invites patients to examine their behaviors with the hope of promoting self-awareness and integration (99, 100).

Building a collaborative treatment alliance with patients is both a strategy to increase the effectiveness of treatment as well as a treatment goal (2). Attention to the patient's inner experiences and behaviors, curiosity, and a nonjudgmental stance help throughout the treatment. Attention to the therapeutic relationship invites work on the ability to negotiate conflicting perceptions, staying connected through affective storms, and staying open-minded through cycles of alliance, rupture, and repair (2, 99–101).

Awareness of countertransference helps the clinician gain an understanding of the patient's interpersonal patterns, as well as internal experiences that may remain outside the patient's awareness or verbalization capacities. However, this awareness also invites clinicians to seek consultations when countertransference reactions lead to stalemates.

Treatment is expected to help the patient develop better awareness of maladaptive patterns, increase sense of agency, make progress toward measurable goals, and develop alternatives to maladaptive ways of relating to self (e.g., self-criticism) and others (e.g., admiration seeking, retaliation).

Adding couple's or group therapy may be indicated to address relational patterns. Family therapy educates family members about the disorder, contains treatment-interfering reactions by the family, and, in some cases, addresses family dynamics (98, 99). Case management has proven helpful for patients interested in learning life skills.

Many patients with the disorder have comorbid conditions (mood disorder, anxiety disorder, or substance use disorder) (3). Although NPD needs to be made a priority, other conditions need to be incorporated into the treatment as well. Oftentimes, these disorders can be addressed within the treatment for NPD. However, if the patient presents with unmanaged bipolar disorder, substance use, a severe eating disorder, or obsessive-compulsive disorder, treatment of these comorbid disorders will likely require a separate focus. Such therapy may include participation in specialized substance use or eating disorder treatments.

AUTHOR AND ARTICLE INFORMATION

Department of Psychiatry, Harvard Medical School, McLean Hospital, Belmont, Massachusetts. Send correspondence to Dr. Weinberg (iweinberg@mclean.harvard.edu).

The authors report no financial relationships with commercial interests.

REFERENCES

1. Diagnostic and Statistical Manual of Mental Disorders, 5th ed, Text Revision. Washington, DC, American Psychiatric Association, 2022
2. Weinberg I, Ronningstam E: Dos and don'ts in treatments of patients with narcissistic personality disorder. J Pers Disord 2020; 34(suppl):122–142
3. Ronningstam E, Weinberg I: Narcissistic personality disorder: progress in recognition and treatment. Focus 2013; 11:167–177
4. Eaton NR, Rodriguez-Seijas C, Krueger RF, et al: Narcissistic personality disorder and the structure of common mental disorders. J Pers Disord 2017; 31:449–461
5. Miller JD, Campbell WK, Pilkonis PA: Narcissistic personality disorder: relations with distress and functional impairment. Compr Psychiatry 2007; 48:170–177
6. Ellison WD, Acuff MC, Kealy D, et al: Narcissism and quality of life: the mediating role of relationship patterns. J Nerv Ment Dis 2020; 208:613–618
7. Miller JD, Gentile B, Wilson L, et al: Grandiose and vulnerable narcissism and the DSM-5 pathological personality trait model. J Pers Assess 2013; 95:284–290
8. Pincus AL, Lukowitsky MR: Pathological narcissism and narcissistic personality disorder. Annu Rev Clin Psychol 2010; 6: 421–446
9. Weinberg I: Categorical model of personality disorders; in The Cambridge Handbook of Personality Disorders. Edited by Lejuez CW, Gratz KL. Cambridge, UK, Cambridge University Press, 2020
10. Skodol AE, Bender DS, Morey LC: Narcissistic personality disorder in DSM-5. Personal Disord 2014; 5:422–427
11. Schalkwijk F, Luyten P, Ingenhoven T, et al: Narcissistic personality disorder: are psychodynamic theories and the alternative DSM-5 model for personality disorders finally going to meet? Front Psychol 2021; 12:676733
12. Mulder RT: ICD-11 personality disorders: utility and implications of the new model. Front Psychiatry 2021; 12:655548
13. International Statistical Classification of Diseases and Related Health Problems (ICD 11). Geneva, World Health Organization [WHO], 2019
14. Skodol AE: Personality disorders in DSM-5. Annu Rev Clin Psychol 2012; 8:317–344
15. Wink P: Two faces of narcissism. J Pers Soc Psychol 1991; 61: 590–597
16. Dickinson KA, Pincus AL: Interpersonal analysis of grandiose and vulnerable narcissism. J Pers Disord 2003; 17:188–207
17. Russ E, Shedler J, Bradley R, et al: Refining the construct of narcissistic personality disorder: diagnostic criteria and subtypes. Am J Psychiatry 2008; 165:1473–1481
18. Ackerman RA, Donnellan MB, Wright AGC: Current conceptualizations of narcissism. Curr Opin Psychiatry 2019; 32:32–37
19. Jauk E, Ulbrich L, Jorschick P, et al: The non-linear association between grandiose and vulnerable narcissism: an individual data meta-analysis. J Pers (Epub Dec 3, 2021). doi: 10.1111/jopy.12692
20. Edershile EA, Wright AGV: Fluctuations in grandiose and vulnerable narcissistic states: a momentary perspective. J Pers Soc Psychol 2021; 120:1386–1414
21. Kealy D, Sandhu S, Ogrodniczuk JS: Looking ahead through a fragile lens: vulnerable narcissism and the future self. Personal Ment Health 2017; 11:290–298
22. Huprich SK: Commentary on the special issue: critical distinctions between vulnerable narcissism and depressive personalities. J Pers Disord 2020; 34(suppl):207–209
23. Gore WL, Widiger TA: Fluctuation between grandiose and vulnerable narcissism. Personal Disord 2016; 7:363–371
24. Horowitz MJ: Sliding meanings: a defense against threat in narcissistic personalities. Int J Psychoanal Psychother 1975; 4: 167–180
25. Symington N: Narcissism: A New Theory. London, Routledge, 1992
26. Andersen SM, Schwartz AH: Intolerance of ambiguity and depression: a cognitive vulnerability factor linked to hopelessness. Soc Cogn 1992; 10:271–298
27. Masterson J: Search for the Real Self. New York, The Free Press, 1993
28. Pincus AL, Cain NM, Wright AGC: Narcissistic grandiosity and narcissistic vulnerability in psychotherapy. Personal Disord 2014; 5:439–443
29. Stepp SD, Lazarus SA, Byrd AL: A systematic review of risk factors prospectively associated with borderline personality disorder: taking stock and moving forward. Personal Disord 2016; 7: 316–323
30. Vater A, Ritter K, Schroder-Abe M, et al: When grandiosity and vulnerability collide: implicit and explicit self-esteem in patients with narcissistic personality disorder. J Behav Ther Exp Psychiatry 2013; 44:37–47
31. Thompson G, Glasø L, Martinsen O: Antecedents and consequences of envy. J Soc Psychol 2016; 156:139–153
32. Ritter K, Vater A, Rusch N, et al: Shame in patients with narcissistic personality disorder. Psychiatry Res 2014; 215:429–437
33. Ronningstam E: Intersect between self-esteem and emotional regulation in NPD—implications for alliance building and treatment. Borderline Pers Disord Emotional Regul 2017; 4:1–13
34. Marissen MAE, Deen ML, Franken IHA: Disturbed emotion recognition in patients with narcissistic personality disorder. Psychiatry Res 2012; 198:269–273
35. De Panfilis C, Antonucci C, Meehan KB, et al: Facial emotion recognition and social-cognitive correlates of narcissistic features. J Pers Disord 2019; 33:433–449
36. Ronningstam E, Baskin-Sommers AR: Fear and decision-making in narcissistic personality disorder—a link between psychoanalysis and neuroscience. Dialogues Clin Neurosci 2013; 15:191–201
37. Tangney JP, Wagner P, Fletcher C, et al: Shamed into anger? The relationship of shame and guilt to anger and self-reported aggression. J Pers Soc Psychol 1992; 62:669–675
38. Besser A, Priel B: Grandiose narcissism versus vulnerable narcissism in threatening situations: emotional reactions to achievement failure and interpersonal rejection. J Soc Clin Psychol 2010; 29:874–902
39. Bach S: On the narcissistic state of consciousness. Int J Psychoanal 1977; 58:209–233
40. Yang Z, Sedikides C, Gu R, et al: Narcissism and risky decisions: a neurophysiological approach. Soc Cogn Affective Neurosci 2018; 13:889–897
41. Kealy D, Ogrodniczuk JS: Narcissistic interpersonal problems in clinical practice. Harv Rev Psychiatry 2011; 19:290–301
42. Day NJS, Townsend ML, Grenyer BFS: Pathological narcissism: an analysis of interpersonal dysfunction within intimate relationships. Personal Ment Health (Epub Nov 16, 2021). doi: 10.1002/pmh.1532
43. Back MD, Kufner ACP, Dufner M, et al.: Narcissistic admiration and rivalry: disentangling the bright and dark sides of narcissism. J Pers Soc Psychol 2013; 105:1013–1037
44. Chester DS, DeWall CN: Sound the alarm: the effect of narcissism on retaliatory aggression is moderated by dACC reactivity to rejection. J Pers 2016; 84:361–368
45. Wright AGC, Stepp SD, Scott LN, et al: The effect of pathological narcissism on interpersonal and affective processes in social interactions. J Abnormal Psychol 2017; 126:898–910
46. Diamond D, Levy KN, Clarkin JF, et al: Attachment and mentalization in female patients with co-morbid narcissistic and borderline personality disorder. Personal Disord 2014; 5: 428–433
47. Cramer P: Narcissism and attachment: the importance of early parenting. J Nerv Ment Dis 2019; 207:69–75

48. Van Schie CC, Jarman HL, Reis S, et al: Narcissistic traits in young people and how experiencing shame relates to current attachment challenges. BMC Psychiatry 2021; 21:246
49. Ritter K, Dziobek I, Preissler S, et al: Lack of empathy in patients with narcissistic personality disorder. Psychiatry Res 2011; 187: 241–247
50. Baskin-Sommers A, Krusemark E, Ronningstam E: Empathy in narcissistic personality disorder: from clinical and empirical perspective. Personal Disord 2014; 5:323–333
51. Ronningstam E: Internal processing in patients with pathological narcissism or narcissistic personality disorder: implications for alliance building and therapeutic strategies. J Pers Disord 2020; 34:80–103
52. Eddy CM: Self-serving social strategies: a systematic review of social cognition in narcissism. Curr Psychol (Epub May 1, 2021). doi: 10.1007/s12144-021-01661-3
53. Akhtar S: Broken Structures. New York, Aronson, 1992
54. Clemens V, Fegert JM, Allroggen M: Adverse childhood experiences and grandiose narcissism–findings from a population-representative sample. Child Abuse Negl 2022; 127:105545
55. Cohen LJ, Tanis T, Bhattacharjee R, et al: Are there differential relationships between different types of childhood maltreatment and different types of adult personality pathology? Psychiatry Res 2014; 215:192–201
56. Keene AC, Epps J: Childhood physical abuse and aggression: shame and narcissistic vulnerability. Child Abuse Negl 2016; 51: 276–283
57. Hengartner MP, Ajdacic-Gross V, Rodgers S, et al: Childhood adversity in association with personality disorder dimensions: new findings in an old debate. Eur Psychiatry 2013; 28:476–482
58. Johnson JG, Cohen P, Smailes EM, et al: Childhood verbal abuse and risk for personality disorders during adolescence and early adulthood. Compr Psychiatry 2001; 42:16–23
59. Wetzel E, Robins RW: Are parenting practices associated with the development of narcissism? Findings from a longitudinal study of Mexican-origin youth. J Res Pers 2016; 63:84–94
60. Bertele N, Talmon A, Gross JJ: Childhood maltreatment and narcissism: the mediating role of dissociation. J Interpers Violence 2022; 37:NP9525–NP9547
61. Brummelman E, Thomaes S, Nelemans SA, et al: Origins of narcissism in children. Proc Natl Acad Sci 2015; 112:3659–3662
62. Van Schie CC, Jarman HL, Huxley E, et al: Narcissistic traits in young people: understanding the role of parenting and maltreatment. Borderline Personal Disord Emotional Dysregulation 2020; 7:10
63. Huxley E, Bizumic B: Parental invalidation and the development of narcissism. J Psychol 2017; 151:130–147
64. Horton RS, Bleau G, Drwecki B: Parenting narcissus: what are the links between parenting and narcissism? J Pers 2006; 74: 345–376
65. Otway LJ, Vignoles VL: Narcissism and childhood recollections: a quantitative test of psychoanalytic predictions. Pers Soc Psychol Bull 2006; 32:104–116
66. Watson PJ, Hickman SE, Morris RJ, et al: Narcissism, self-esteem, and parental nurturance. J Psychol 1995; 129:61–73
67. Horton RS, Tritch T: Clarifying the links between grandiose narcissism and parenting. J Psychol 2014; 148:133–143
68. Winner NA, Nicholson BC: Overparenting and narcissism in young adults: the mediating role of psychological control. J Child Fam Stud 2018; 27:3650–3657
69. Segrin C, Woszidlo A, Givertz M, et al: Parenting and child traits associated with overparenting. J Soc Clin Psychol 2013; 32: 569–595
70. Segrin C, Woszidlo A, Givertz M, et al: The association between overparenting, parent-child communication, and entitlement and adaptive traits in adult children. Fam Relations 2012; 61:237–252
71. Carlson KS, Gjerde PF: Preschool personality antecedents of narcissism in adolescence and emergent adulthood: a 20-year longitudinal study. J Res Pers 2009; 43:570–578
72. Cramer P: Childhood precursors of the narcissistic personality. J Nerv Ment Dis 2017; 205:679–684
73. Leclere C, Viaux S, Avril M, et al: Why synchrony matters during mother-child interactions: a systematic review. PLoS One 2014; 9: 113571
74. Fonagy P, Gergely G, Jurist EL, et al: Affect Regulation, Mentalization, and the Development of the Self. New York, Other Press, 2002
75. Hong RY, Lee SSM, Chng RY, et al: Developmental trajectories of maladaptive perfectionism in middle childhood. J Pers 2017; 85: 409–422
76. Plakun EM: Narcissistic personality disorder. A validity study and comparison to borderline personality disorder. Psychiatr Clin North Am 1989; 12:603–620
77. McGlashan TH, Heinssen RK: Narcissistic, antisocial, and non-comorbid subgroups of borderline disorder. Are they distinct entities by long-term clinical profile? Psychiatr Clin North Am 1989; 12:653–670
78. Stone MH: Long-term follow-up of narcissistic/borderline patients. Psychiatr Clin North Am 1989; 12:621–641
79. Ronningstam E, Gunderson J, Lyons M: Changes in pathological narcissism. Am J Psychiatry 1995; 152:253–257
80. Vater A, Ritter K, Strunz S, et al: Stability of narcissistic personality disorder: tracking categorical and dimensional rating systems over a two-year period. Personal Disord 2014; 5:305–313
81. Durbin CE, Klein DN: Ten-year stability of personality disorders among outpatients with mood disorders. J Abnorm Psychol 2006; 115:75–84
82. Hopwood CJ, Morey LC, Donnellan MB, et al: Ten-year rank-order stability of personality traits and disorders in a clinical sample. J Pers 2013; 81:335–344
83. Lenzenweger MF: Stability and change in personality disorder features: the Longitudinal Study of Personality Disorders. Arch Gen Psychiatry 1999; 56:1009–1015
84. Hallquist MN, Lenzenweger MF: Identifying latent trajectories of personality disorder symptom change: growth mixture modeling in the Longitudinal Study of Personality Disorders. J Abnorm Psychol 2013; 122:138–155
85. Cramer P: Narcissism through the ages: what happens when narcissists grow older? J Res Personal 2011; 45:479–492
86. Lenzenweger MF, Clarkin JF, Caligor E, et al: Malignant narcissism in relation to clinical change in borderline personality disorder: an exploratory study. Psychopathology 2018; 51:318–325
87. Hilsenroth MJ, Castlebury FD, Holdwick DJ, et al: The effect of DSM-IV Cluster B personality disorder symptoms on the termination and continuation of psychotherapy. Psychotherapy 1998; 35:163–176
88. Gamache D, Savard C, Lemelin S, et al: Premature termination of psychotherapy in patients with borderline personality disorder: a cluster-analytic study. J Nerv Ment Dis 2018; 206:231–238
89. Ellison WD, Levy KN, Cain NM, et al: The impact of pathological narcissism on psychotherapy utilization, initial symptom severity, and early-treatment symptom change: a naturalistic investigation. J Pers Assess 2013; 95:291–300
90. Black RSA, Curran D, Dyer KFW: The impact of shame on the therapeutic alliance and intimate relationships. J Clin Psychol 2013; 69:646–654
91. Blatt SJ, Zuroff DC, Bondi CM, et al: When and how perfectionism impedes the brief treatment of depression: further analyses of the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J Consult Clin Psychol 1998; 66:423–428

92. Dozier M, Lomax L, Tyrrell CL, et al: The challenge of treatment for clients with dismissing states of mind. Attach Hum Dev 2001; 3:62–76
93. Guile JM, Mbekou V, Lageix P: Child and parent variables associated with treatment response in narcissistic youths: the role of self-blame and shame. Can Child Adolesc Psychiatr Rev 2004; 13:81–85
94. Tanzilli A, Muzi L, Ronningstam E, et al: Countertransference when working with narcissistic personality disorder: an empirical investigation. Psychotherapy (Chic) 2017; 54:184–194
95. Callaghan GM, Summers CJ, Weidman M: The treatment of histrionic and narcissistic personality disorder behaviors. J Contemp Psychotherapy 2003; 33:321–339
96. Riordan RW: The management of narcissistic vulnerability: three case studies guided by Stephen Mitchell's Integrated Treatment Model. Pragmatic Case Stud Psychotherapy 2012; 8:150–203
97. Kramer U, Pascual-Leone A, Rohde KB, et al: The role of shame and self-compassion in psychotherapy for narcissistic personality disorder: an exploratory study. Clin Psychol Psychother 2018; 25: 272–282
98. Weinberg I, Finch EF, Choi-Kain L: Implementation of good psychiatric management for narcissistic personality disorder. Good enough or not good enough? GPM approach to other personality disorders; in Good Psychiatric Management for Borderline Personality Disorder. A Practical Guide. Edited by Choi-Kain LW, Gunderson JG. Washington, DC, American Psychiatric Association, 2019
99. Diamond D, Hersh RG: Transference-focused psychotherapy for narcissistic personality disorder: an object relations approach. J Pers Disord 2020; 34(suppl):159–176
100. Crisp H, Gabbard GO: Principles of psychodynamic treatment for patients with narcissistic personality disorder. J Pers Disord 2020; 34(suppl):143–158
101. Drozek RP, Unruh BT: Mentalization-based treatment for pathological narcissism. J Pers Disord 2020; 34(suppl):177–203

Appreciation to Reviewers

As *Focus* concludes another successful year, we thank the following individuals who reviewed submissions to the journal. The quality of articles published these past 2 years was due in no small part to the valuable insights provided by these individuals.

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