Narcissistic Personality Disorder: Diagnostic and Clinical Challenges

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FOUR DIFFERENT FACES OF NARCISSISTIC PERSONALITY DISORDER

"Mr. A" is a 42-year-old married man presenting to a private-practice psychotherapist complaining of problems with his wife. He is a successful entrepreneur, highly competitive, who describes enjoying social gatherings, where he tends to be the center of attention, as well as challenges at work, where he believes that he has a superior ability to solve problems. He comes to treatment because he is wondering whether or not to stay in his marriage. Mr. A described having lost all sexual interest in his wife during their early years together. Throughout the marriage, he has maintained a series of lovers whom he has housed, supported, and then cut off and replaced. He feels that this arrangement has had no impact on his relationship with his wife but wonders if he would do better with someone else.

"Mr. B" is a 34-year-old single man with a history of cocaine and alcohol abuse, currently unemployed. He presented to the emergency department complaining of pain following a dental procedure and requesting Percocet (acetaminophen and oxycodone). Although he was initially ingratiating with the attending physician who took his history, when she explained that she would have to speak with his oral surgeon before writing a prescription for a narcotic, Mr. B began to insult and bully her. The attending spoke with Mr. B's "girlfriend," whose contact information he had provided. The girlfriend explained that she had recently broken things off with Mr. B because he had been exploiting her financially; since being fired 1 year earlier from a high-paying financial job, he had been unable to find employment that met his lofty expectations for himself, preferring instead to live off money from his father and his girlfriend.

"Mr. C" is a 29-year-old single man with a history of insulin-dependent diabetes who presents to an outpatient clinic for treatment of dysthymia and social phobia. He has held a series of low-level jobs that "have not worked out," and he currently works part-time doing data entry. Mr. C described his mood as chronically "miserable." Socially isolated and easily slighted, he has no interests, takes pleasure in nothing, and routinely wonders "whether life is worth living." When feeling down, he often "forgets" to administer his insulin, resulting in multiple hospitalizations for hyperglycemia. He constantly compares himself with others, feeling envious and resentful, and describes himself as deficient and defective. At the same time, he resents that others fail to recognize all he has to offer. At times he engages in fantasies of his employer publicly acknowledging his special talents and promoting him; at other times, he has fantasies of humiliating his boss with a display of superior knowledge.

"Ms. D" is a 44-year-old single woman referred to a group specializing in severe personality disorders. She complained of "refractory depression" for which she was on medical disability. She had been treated for 10 years with every modality her local hospital could offer, including ECT. She portrayed her previous therapists in scathingly derogatory terms, seeming to find gratification in their failed attempts to help her. Her group therapist diagnosed her with narcissistic personality disorder based on the gap between her self-image as an extremely gifted but unrecognized author and the reality that she had written almost nothing. Antisocial features consisted of chronic lying, a history of prostitution in her 20s, and "working the system" to obtain disability payments rather than taking on work that she was able to do. There were no neurovegetative symptoms of depression. When her new therapist raised the possibility of working toward employment, Ms. D coolly declared that she would kill herself, or him, if he interfered with her ability to obtain her benefits.

Narcissistic personality disorder is prevalent, highly comorbid with other disorders, and associated with significant functional impairment and psychosocial disability (1, 2). However, it has been one of the least studied personality disorders. As a result, there is a fair amount of confusion regarding the reliability, validity, specificity, and sensitivity of diagnostic

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criteria, as well as the prevalence of the disorder, and to date there have been no randomized clinical trials examining the efficacy of any treatment for the disorder (3). In fact, because of the limited research literature, narcissistic personality disorder was initially slated to be omitted from DSM-5. However, in response to feedback from the clinical and research community (e.g., 4–8) this decision was reversed, and narcissistic personality disorder was included in Section II of DSM-5 (Diagnostic Criteria and Codes) and also reconstructed in Section III (Emerging Measures and Models).

DEFINITION AND DIAGNOSTIC CHALLENGES

Diagnostic confusion surrounding narcissistic personality disorder reflects the disorder's highly variable presentation and the wide range of severity that can characterize narcissistic pathology. Individuals with narcissistic personality disorder may be grandiose or self-loathing, extraverted or socially isolated, captains of industry or unable to maintain steady employment, model citizens or prone to antisocial activities. Given this heterogeneity, it is far from self-evident what such individuals could have in common to justify a shared diagnosis. The DSM-5 criteria (Table 1) to some degree sidestep this question by providing a rather narrow and homogeneous definition of narcissistic personality disorder characterized by a pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, entitlement, and lack of empathy. However, while these criteria capture important aspects of narcissistic pathology, they provide inadequate coverage of the broad population of individuals who receive the diagnosis in clinical practice (9–11), and they fail to cover core psychological features of the disorder, including vulnerable self-esteem; feelings of inferiority, emptiness, and boredom; and affective reactivity and distress (11). Furthermore, because DSM-5 criteria are, a priori, limited to observable features of psychopathology, the description of narcissistic personality disorder in Section II of DSM-5 does not address underlying psychological structures or dynamic constellations that can be seen to organize and unify the various presentations of the disorder.

SUBTYPES AND CORE PSYCHOLOGICAL FEATURES

Although DSM-5 describes a single, relatively homogeneous syndrome, there is a rich literature supporting the existence of different subtypes of narcissistic personality disorder (12–22). The clinical vignettes we provide here of four patients diagnosed with narcissistic personality disorder illustrate both the variable presentation of the disorder with regard to descriptive features ("subtypes") and the broad spectrum of severity of pathology associated with the disorder. Typical presentations of narcissistic personality disorder are the grandiose, "overt," subtype, corresponding closely to the DSM-5 criteria and illustrated in the vignettes by Mr. B; the vulnerable, "covert," subtype, less well covered in current diagnostic criteria, illustrated by Mr. C; and the healthier, "high-functioning" subtype illustrated by Mr. A.

The grandiose, thick-skinned, overt subtype is characterized by overt grandiosity, attention seeking, entitlement, arrogance, and little observable anxiety. These individuals can be socially charming, despite being oblivious to the needs of others, and are interpersonally exploitative. In contrast, the vulnerable, "fragile" or thin-skinned, covert subtype is inhibited, manifestly distressed, hypersensitive to the evaluations of others while chronically envious and evaluating themselves in relation to others. Interpersonally these individuals are often shy, outwardly self-effacing, and hypersensitive to slights, while harboring secret grandiosity. Both types are extraordinarily self-absorbed. Many individuals with narcissistic personality disorder fluctuate between grandiose and depleted states, depending on life circumstances, while others may present with mixed features (11, 15, 17, 22). In addition to the grandiose and vulnerable subtypes, there is a healthier group of individuals with narcissistic personality disorder, described as "high-functioning," "exhibitionistic," or "autonomous." These individuals, illustrated by Mr. A, are grandiose, competitive, attention seeking, and sexually provocative, while demonstrating adaptive functioning and using their narcissistic traits to succeed. Because of their high level of functioning, at first glance individuals in this group may not appear to have a personality disorder, and the narcissistic personality disorder diagnosis can be overlooked on diagnostic assessment.

An appreciation of the various subtypes of narcissistic personality disorder leads to the question of what are the core psychological features that define narcissistic personality disorder and that can in turn be relied upon to inform clinical assessment and treatment planning. This issue is addressed to some degree in the alternative model for conceptualizing personality disorders developed by the DSM-5 Work Group and included in Section III of DSM-5. This model goes beyond the familiar focus on the descriptive features of different personality disorders to emphasize additionally the role of impairment of self and interpersonal functioning in personality pathology. For narcissistic personality disorder, Section III identifies deficits in self-definition, self-esteem and affect regulation, and consolidation of internal goals and standards as core features of the disorder; interpersonal relations are "functional," serving to support the sense of self and/or to provide personal gain, and capacity for intimacy is lacking (Table 2).

Our own approach to characterizing and understanding narcissistic personality disorder is compatible with the alternative model developed by the DSM-5 Work Group and also with psychodynamic models of narcissistic personality disorder based in object relations theory. From a psychodynamic perspective, a specific form of self or identity dynamic is at the core of narcissistic pathology (15). Rather than the flexible and reality-based self-experience that characterizes normal identity formation, the sense of self in narcissistic personality disorder is brittle and somewhat removed from reality; what characterizes narcissistic personality disorder across the spectrum is a more or less fragile sense of self that is predicated on maintaining a view of oneself as exceptional. This characterization applies not only to grandiose

narcissists, but also to those in the vulnerable subtype, where grandiosity is cloaked in feelings of inferiority and deficiency. Maintaining a grandiose sense of self can provide a more or less stable self-experience for the individual with narcissistic personality disorder, but comes at a cost, requiring a retreat from or denial of realities that do not support grandiosity, and leaving the individual excessively reliant on external feedback to support not only positive self-regard but also self-definition. The specific pathology of identity formation that characterizes narcissistic personality disorder also lends itself to characteristic disruptions in interpersonal functioning. On the one hand, individuals with narcissistic personality disorder often have a profound need for others to support their sense of self and also to help with self-esteem regulation. On the other hand, genuine engagement with others can threaten the stability of the grandiose sense of self, by confronting the individual with the painful reality that others have attributes that they lack. As a result, those with more grandiose features tend to engage in superficial relationships organized to support self-esteem and self-definition, while those with more vulnerable features tend to withdraw from social situations; for both types, self-regulatory needs leave little room for genuine interest in the needs or feelings of others.

PREVALENCE AND COMORBIDITY

The prevalence of narcissistic personality disorder remains poorly defined, reflecting the lack of clarity around the diagnosis. Commonly cited prevalence estimates range from 0% to 5.3% in the general population (11). Prevalence in clinical samples has been reported to range from 1% to 17% (11). In a recent large adult community sample, risk factors included male sex, younger age, and single marital status (2).

Narcissistic personality disorder is frequently comorbid with other disorders, particularly substance use disorders, bipolar disorder, and other personality disorders (2, 23, 24), and comorbid disorders are often what first brings individuals with narcissistic personality disorder to clinical attention. The degree of comorbidity is linked to severity (25). Narcissistic personality disorder most commonly co-occurs with antisocial, histrionic, borderline, schizotypal, and passive-aggressive personality disorders (3); comorbidity with antisocial personality disorder has the most profound negative impact on prognosis.

Grandiose and vulnerable narcissistic subtypes are associated with different patterns of comorbidity (22). Depression and anxiety are more common in the vulnerable narcissistic group, as are nonsuicidal self-injury and suicide attempts (16, 17, 19). In contrast, those with the grandiose subtype or in grandiose states may be relatively free of subjective distress unless confronted with professional or interpersonal failures (15, 18). Grandiose traits tend to be related to substance abuse and comorbidity with antisocial and paranoid personality disorder (19).

CLINICAL PRESENTATION AND CLINICAL CHALLENGES

Individuals with narcissistic personality disorder constitute some of the highest-functioning patients seen in outpatient settings and also some of the most impaired and intractable among patients seen in emergency departments and on inpatient units. In fact, of all the personality disorders, narcissistic personality disorder spans the broadest spectrum of severity (15). As a result, it is useful to distinguish not only between grandiose/overt and vulnerable/covert clinical presentations, but also among different levels of severity of narcissistic personality disorder. In general, as severity of narcissistic pathology increases, aggression, which can be directed at oneself as well as others, becomes more evident, interpersonal functioning deteriorates, and deficiencies in moral functioning become increasingly prominent, posing significant challenges to clinical management (26, 27). More severe forms of narcissistic personality disorder challenge clinicians to limit patients' destructive and self-destructive behavior. In addition, it is necessary to minimize secondary gain (benefits derived from being ill), which often involves insisting that patients seek appropriate employment and may require involvement of family members in treatment.

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At the highest level of functioning, patients like Mr. A are able to achieve the admiration necessary to gratify their grandiose needs. These individuals may function successfully, although they may be susceptible to breakdowns in response to setbacks or advancing age. Like Mr. A, psychopathology may be evident primarily in a transactional view of intimate relations, which are characterized by superficiality and lack of genuine concern for the needs or the feelings of the other. Individuals in this group rarely seek treatment; when they do, it is often only at the insistence of significant others or during an acute crisis.

At the middle level of functioning, patients like Mr. B present with an obviously distorted, grandiose sense of self and have little interest in intimacy. These individuals may function adequately or even well professionally, despite significant interpersonal difficulties, or they may refuse to work, especially if they do not have access to narcissistically gratifying employment. Mr. B demonstrates grandiosity in his refusal to take on work he sees as beneath him, preferring to be unemployed, entitlement in his demands for medication in the emergency department, and financial exploitation of his parents and girlfriend. Problems in his sense of self are joined with a view of others as a means to an end rather than a source of mutual gratification. Motivation for treatment can be limited; Mr. B would likely have no interest in treatment unless his family demanded it as a condition of continued financial support.

At a lower level of functioning are patients like Mr. C, who present with comorbid borderline personality traits. In

TABLE 1. DSM-5 Criteria for Narcissistic Personality Disorder[a]

A pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Has a grandiose sense of self-importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements).
2. Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love.
3. Believes that he or she is "special" and unique and can only be understood by or should associate with, other special or high-status people (or institutions).
4. Requires excessive admiration.
5. Has a sense of entitlement (i.e., unreasonable expectation of especially favorable treatment or automatic compliance with his or her expectations).
6. Is interpersonally exploitative (i.e., takes advantage of others to achieve his or her own ends).
7. Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others.
8. Is often envious of others or believes that others are envious of him or her.
9. Shows arrogant, haughty behaviors and attitudes.

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TABLE 2. Proposed Criteria for Narcissistic Personality Disorder in the Alternative DSM-5 Model for Personality Disorders[a]

A. Moderate or greater impairment in personality functioning, manifested by characteristic difficulties in two or more of the following four areas:

1. **Identity:** Excessive reference to others for self-definition and self-esteem regulation; exaggerated self-appraisal inflated or deflated, or vacillating between extremes; emotional regulation mirrors fluctuations in self-esteem.
2. **Self-direction:** Goal setting based on gaining approval from others; personal standards unreasonably high in order to see oneself as exceptional, or too low based on a sense of entitlement; often unaware of own motivations.
3. **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 underestimate of own effect on others.
4. **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.

B. Both of the following pathological personality traits:

1. **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; condescension toward others.
2. **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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contrast to the higher-functioning group, these individuals exhibit a sense of self that is poorly defined and unstable; they frequently oscillate between pathological grandiosity and suicidality. Mr. C demonstrates self-directed aggression in his noncompliance with diabetes care, antisocial features to the extent that he misrepresents the cause of his hyperglycemia to his physicians, and extremely poor interpersonal functioning characterized by a lack of interest in relationships. In addition to demonstrating features of lower-level narcissistic pathology, Mr. C presents the challenge of vulnerable narcissism, appearing submissive and inadequate, but with a self-concept based on a covert sense of superiority. The gap between an unrealistic and extremely fragile sense of self and objective reality leads to a lack of engagement in the world, as any meaningful contact with others (including treatment providers) challenges his covert grandiosity.

Finally, at the greatest level of severity are those like Ms. D who suffer from "malignant narcissism" (28). The illnesses of these patients are characterized by the typical symptoms of narcissistic personality disorder; however, these patients also display prominent antisocial behavior, tend toward paranoid features, and take pleasure in their aggression and sadism toward others. Individuals in this group are the most difficult to treat: chronic lying and the sadistic pleasure in controlling and even frightening and intimidating clinicians can overwhelm any possibility of working therapeutically. In addition, secondary gains, which can be financial or interpersonal, provide a powerful motivation for the patient to maintain the status quo; often there is no hope for change unless the treatment team works with the patient's social system to limit or eliminate secondary gain.

ASSESSMENT

Because of the sometimes subtle presentation of narcissistic personality disorder, especially at the higher-functioning end of the spectrum, and because of the centrality of interpersonal difficulties in the disorder, a systematic clinical interview may be the most reliable way to diagnose narcissistic personality disorder. Kernberg's structural interview (29) is one such clinical interview, and it is also available in modified form as a semistructured interview (30). While structured assessments for narcissistic personality disorder, in both self-report and structured interview formats, have demonstrated reliability and utility for research, they add little to the interview of a skilled clinician.

In the clinical interview, focusing on the patient's description of significant others can help in diagnosing narcissistic personality disorder. These descriptions are characteristically dismissive or derogating or, alternatively, colored by idealization. Most striking, however, is the markedly superficial and vague, shadowy quality of the narcissistic individual's experience of others. In addition, individuals with narcissistic personality disorder demonstrate a tendency to describe others in terms of how others are similar to or different from themselves. In contrast, the narcissistic individual's sense of him- or herself may be more intact and nuanced, albeit colored by grandiosity or self-deprecation. The clinician's personal reactions to the individual with narcissistic personality disorder can call attention to the diagnosis. Common reactions to patients with

narcissistic personality disorder include feeling idealized and pressured to provide a magic cure, feeling belittled and devalued, feeling treated like someone who is incompetent and has nothing to offer, or feeling like a sounding board, ignored, without recognition of the clinician as an individual or any interest in what he or she might have to say (19, 31, 32).

DIFFERENTIAL DIAGNOSIS

The differential diagnosis for narcissistic personality disorder includes bipolar illness, substance abuse, depressive disorders, especially treatment refractory depression, and anxiety disorders, as well as other personality disorders. All are frequently comorbid with narcissistic personality disorder, complicating diagnostic and clinical decision making; it is often unclear whether symptoms of anxiety or depression, for example, reflect a comorbid diagnosis or are primarily an expression of personality pathology. While manic states can mimic many of the features of grandiose narcissism, the admiration seeking and devaluation of others characteristic of narcissistic personality disorder are typically absent in manic individuals. One can imagine that Mr. A, when excited by a new business idea, might demonstrate the kind of expansiveness and exuberant enthusiasm seen in hypomania. In this setting, his need to have his superior creativity and effectiveness admired by others would help to distinguish his behavior from that of someone who is hypomanic. Chronic substance abuse can affect psychological functioning to simulate narcissistic personality disorder; the individual with a chronic substance use disorder may become exploitative, self-focused, lacking in empathy, and ruthless, often in conjunction with antisocial features. This syndrome could potentially be at play with Mr. B, and establishing the narcissistic personality disorder diagnosis would require careful assessment of his substance abuse history as well as of his personality functioning across time. Symptoms associated with major depression, dysthymia, social anxiety, and generalized anxiety disorder overlap with features of vulnerable narcissism. In this setting, one can avoid missing the narcissistic personality disorder diagnosis by careful evaluation of the patient's sense of self and interpersonal functioning. For example, despite Mr. C's complaints of depression and social anxiety, his covert grandiosity is incompatible with a diagnosis of a major affective or anxiety disorder alone. Similarly, Ms. D's grandiosity and entitlement do not fit with the diagnosis of major depression, despite her many years of treatment. In addition, the absence of all meaningful relationships demonstrated by both Mr. C and Ms. D would be difficult to account for on the basis of depression and anxiety.

The personality disorders most commonly in the differential diagnosis for narcissistic personality disorder are histrionic, borderline, and antisocial. It is the characteristic grandiosity and need for admiration that most clearly distinguish narcissistic personality disorder from these other diagnostic groups. Narcissistic personality disorder and borderline personality disorder can be further distinguished by the relative instability of the sense of self, along with the impulsivity and self-destructiveness of borderline personality disorder. Mr. C, who presents with comorbid borderline and narcissistic personality disorders, illustrates these features. Histrionic personality disorder and narcissistic personality disorder are both characterized by the need to be the center of attention, but individuals with histrionic personality disorder have a greater capacity for dependent relations than do those with narcissistic personality disorder, and they are more emotionally expressive and less dismissive of others. Despite his superficially good interpersonal functioning and attention seeking, Mr. A can be distinguished from the individual with histrionic personality disorder on the basis of his callous and self-serving attitude toward the women in his life, his lack of overt emotionality, and his view of himself as exceptional. Antisocial personality disorder and narcissistic personality disorder share the traits of exploitation, superficiality, and lack of empathy, but even at the more severe end of the spectrum, individuals with narcissistic personality disorder do not demonstrate the total breakdown of moral functioning and absence of any capacity for loyalty that typifies antisocial personality disorder, nor is narcissistic personality disorder typically associated with the history of childhood conduct disorder that is common in antisocial personality disorder.

TREATMENT

The efficacy of psychotherapeutic and psychopharmacological treatment approaches for narcissistic personality disorder has not been systematically or empirically investigated (3). Clinical practice guidelines for the disorder have yet to be formulated, and psychopharmacologic intervention is symptom driven. Regardless of severity, the grandiosity and defensiveness that characterize narcissistic personality disorder militate against acknowledging problems and vulnerabilities and make engagement in any form of psychotherapy difficult (33).

In patients presenting with major psychiatric disorders, co-occurring narcissistic personality disorder is known to increase the likelihood of treatment dropout and may slow symptom change (34, 35). With this group of patients, discussion of diagnostic issues, including the contribution of personality pathology to the symptom picture, should precede initiation of treatment. Discussion of personality pathology helps to establish realistic expectations on the part of the patient and opens the door to discussion of treatments for underlying narcissistic pathology. Failure to have this sort of discussion can result in polypharmacy or multiple courses of ineffective treatments devoted to chasing refractory symptoms, as exemplified by the case of Ms. D in the vignettes.

When it comes to treatments targeting narcissistic personality disorder per se, current treatment recommendations are based largely on clinical experience and theoretical formulations. Psychodynamic formulations have led to the

proliferation of different treatment approaches, and case reports suggest that these treatments can be effective for some patients. Most influential have been those of Kernberg (36, 37) and Kohut (38, 39), each of which focuses on clinical developments in the relationship between therapist and patient in long-term psychotherapy. In the absence of empirically supported treatments for narcissistic pathology, it is common practice to utilize efficacious treatments for near-neighbor disorders, typically with treatment modifications based on theoretical and clinical rationales regarding differences in the disorders (22). Thus, for patients with narcissistic personality disorder, we recommend referral for empirically supported treatments for borderline personality disorder that have adaptations for narcissistic personality disorder. In particular, we recommend mentalization-based therapy (40), transference-focused psychotherapy (41–43), and schema-focused psychotherapy (44). All three treatments target psychological capacities thought to underlie and organize descriptive features of narcissistic personality disorder. Dialectical behavioral therapy (45) is an additional option for patients with comorbid borderline personality disorder and significant self-destructive acting-out behaviors. All are longer-term treatments that require specialized training of practitioners.

SUMMARY AND RECOMMENDATIONS

Narcissistic personality disorder is a challenging clinical syndrome; it has a variable presentation, is difficult to treat, and complicates the treatment of commonly co-occurring disorders. In the absence of expertise or resources for longer-term treatment of personality disorders, there are specific approaches and techniques that can be implemented to improve general clinical management of patients with the disorder. Based on our review of the literature and clinical experience, we make the following recommendations:

1. Obtain a thorough symptom picture and assessment of psychological, interpersonal, and vocational functioning in order to make a differential diagnosis and establish the presence of narcissistic personality disorder, especially in patients who present with substance abuse, affective illness, anxiety, and/or interpersonal or work-related problems.
2. Assess for vulnerable as well as grandiose forms of narcissistic pathology. Although grandiose presentations may be more obvious and may seem more overtly pathological, vulnerable forms of narcissistic personality disorder are easy to miss and can be equally debilitating and clinically challenging.
3. In any patient for whom narcissistic personality disorder is in the differential diagnosis, assess carefully for pathology of moral functioning (dishonesty, exploitation) as well as frank antisocial features.
4. It is difficult to develop collaborative goals if the patient thinks he or she has a depressive disorder while the therapist thinks the patient has a personality disorder but is reluctant to share that information. Share diagnostic impressions with the patient in the setting of providing psychoeducation and identifying treatment goals. In characterizing narcissistic personality disorder for the patient, focus on problems with self-esteem regulation, lack of satisfaction in their interpersonal lives, and the subjective distress and/or functional impairments that brought the patient to treatment. Some patients may benefit from explicit discussion of the narcissistic personality disorder diagnosis, while others experience the diagnosis as injurious and may do better with a more general discussion focusing on phenomenology and disordered personality functioning.
5. Anticipate that patients with narcissistic personality disorder typically show significant impediments to beginning treatment and engaging fully in the treatment. A clinical approach involving communicating empathy while focusing on specific treatment goals and monitoring one's own internal reactions to the patient can help foster the development of a treatment alliance.
6. Use the patient's words, or preface interventions with comments such as "As you said earlier" to help the patient with narcissistic personality disorder more readily accept the clinician's comments and recommendations.
7. For patients who present with symptoms of depression or anxiety or for substance abuse treatment, adopt standard psychopharmacologic and therapeutic interventions. Anticipate that co-occurrence of narcissistic personality disorder will complicate treatment, increasing risk of dropout, making it more difficult to establish and maintain a therapeutic alliance, and increasing the likelihood of poor response to treatment.
8. Attempt to maintain a nonjudgmental and inquisitive stance toward the patient's difficulties and his or her perception of others, including other clinicians, and steer clear of directly confronting or criticizing the patient's grandiosity.
9. Clinicians' reactions to patients with narcissistic personality disorder tend to be powerful and typically negative; it is helpful to anticipate that one will have to monitor and contain one's emotional reactions to the patient. Patients may begin treatment with idealizations or haughty, devaluating attitudes, both of which can be difficult for clinicians to tolerate, or may vacillate quickly between the two. Pitfalls to be avoided are to respond defensively, aggressively, or dismissively to the narcissistic patient or to withdraw and collude with the patient's denial of pathology through passivity.
10. Attend to negative feelings that the patient may have about the treatment and the clinician. If left unaddressed, these feelings pose a serious threat to the treatment. If addressed in an accepting, nonjudgmental fashion, such discussion can support the development of a treatment

alliance and lead to exploration of the motivations for the patient's negative responses to others and, ultimately, to him- or herself.

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