Narcissistic Personality Disorder: History, Types, Manifestation and Treatment

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Abstract

Narcissistic Personality Disorder (NPD) is a complex psychiatric condition marked by grandiosity, a need for admiration, and a lack of empathy, significantly impairing interpersonal relationships and social functioning. The aim of this paper is to provide an integrative and clinically informed synthesis of disparate theoretical traditions, offering a coherent framework that links historical psychoanalytic concepts with contemporary diagnostic models, clinical typologies, treatment approaches, and emerging neurobiological findings. NPD is examined through a multidisciplinary lens, addressing key psychological constructs, developmental factors, clinical manifestations, and therapeutic challenges. The disorder is often associated with early relational experiences, such as emotional abuse or overindulgence, which contribute to the development of defensive strategies aimed at protecting fragile self-esteem. Clinically, NPD manifests in both overt and covert forms, characterized by a grandiose self-concept that conceals underlying feelings of insecurity and inferiority. Although NPD is frequently regarded as resistant to treatment, contemporary clinical research suggests that meaningful change is possible when interventions target vulnerabilities in self-regulation, affective functioning, and interpersonal dynamics. The distinction between pathological narcissism and healthy self-esteem is emphasized, underscoring that NPD reflects chronic instability of self-worth and reliance on external validation rather than simple self-inflation. Overall, current evidence highlights the importance of multidimensional and integrative frameworks in both the conceptualization and treatment of NPD.

Keywords*:* narcissism, self-esteem, egotism, treatment, disorder

Introduction

Concept and Historical Development of Narcissism

The concept of narcissism has undergone significant transformation since its introduction at the turn of the twentieth century. Initially conceived within psychoanalysis, it has gradually developed into a multidimensional construct spanning psychoanalytic, psychodynamic, empirical, and diagnostic perspectives.

Early Psychoanalytic Foundations

The decisive turning point came with Sigmund Freud's essay On Narcissism (1914), where narcissism was conceptualized as both a developmental stage and a structural element in psychoses and perversions. Freud also described it as a principle of object choice, where the self seeks others resembling what it is, was, or aspires to be (Lunbeck, 2014). These ideas followed earlier psychiatric discussions of autoerotism and sexual self-focus, most notably in the works of Havelock Ellis (1898) and Paul Näcke (1899), which later informed psychoanalytic conceptualizations of narcissism (Sadger, 1908; Freud, 1914).

Post-Freudian Elaborations

Subsequent analysts deepened the clinical meaning of narcissism. Karl Abraham (1919) described characteristic transference resistances, where patients disparaged the analyst. Joan Riviere (1936) introduced the idea of a "negative therapeutic reaction," noting patients' resistance to improvement due to dependency fears. Later, Melanie Klein (1957) and Herbert Rosenfeld (1964, 1971) highlighted envy and aggression as central organizing forces in narcissistic personalities, shaping their destructive object relations.

Mid-20th Century Theoretical Schools

By the 1960s and 1970s, two influential schools emerged. Within ego psychology and object relations theory, Otto Kernberg (1967, 1970, 1974, 1975) conceptualized narcissism as a pathological condition resulting from failures in integrating self- and object-representations. He emphasized splitting defenses, fragile self-esteem, and grandiose self-images rooted in unempathic early caregiving. Kernberg later proposed a dimensional model of narcissism, ranging from normal adult narcissism to pathological forms culminating in narcissistic personality disorder (NPD) (Kernberg, 1984).

Groopman and Cooper (1998) summarized several developmental and environmental factors contributing to narcissistic pathology. These include an oversensitive temperament, inconsistent or unreliable caregiving, excessive admiration without realistic feedback, overindulgence or overvaluation by parents, excessive criticism, and severe emotional abuse in childhood. Such conditions can intensify normal developmental narcissistic traits into pathological forms that persist into adulthood. Some accounts also describe fixation to early childhood stages (ages 3–7) as a Freudian basis for narcissistic arrest, while other studies, such as Gabbard and Twemlow (1994), point to traumatic histories (e.g., incest) as potential risk factors. Importantly, aging and its physical and social limitations have also been noted to exacerbate narcissistic vulnerabilities over time.

In contrast, Heinz Kohut (1971, 1977) advanced self-psychology, redefining narcissism as a libidinal investment in the self, which could be healthy if supported by empathic parenting. For Kohut, deficits in mirroring and idealization during development produced fragile selves compensating through grandiosity or vulnerability. His clinical model emphasized empathy and restoration of selfobject functions as central to therapy.

Types of Narcissists

In addition to broad theoretical models, some authors have proposed more fine-grained typologies of narcissistic personalities, highlighting the heterogeneous ways in which narcissism can manifest.

As described by Alexander Lowen (1975, 1983), narcissistic pathology may manifest through different character expressions rather than discrete diagnostic subtypes. Within his bioenergetic framework, Lowen most prominently described the phallic–narcissistic character, characterized by exhibitionism, competitiveness, sexualization of power, and a need for dominance, alongside variations expressed through compulsive achievement or idealized moral, aesthetic, or spiritual self-images. These manifestations are understood not as distinct types, but as compensatory strategies aimed at sustaining a grandiose self-image and defending against underlying feelings of emptiness and shame.

While Lowen's contribution remains valuable for its emphasis on bodily experience, affect, and vitality, his model has been criticized for limited empirical grounding and for relying on characterological descriptions that are difficult to operationalize within contemporary diagnostic and research frameworks (Schore, 2003; Fonagy et al., 2002). The strong somatic focus, although clinically evocative, offers limited guidance for differential diagnosis and treatment planning within standardized psychiatric systems.

Building on earlier typological efforts, Theodore Millon (1996, 1998) proposed a more differentiated classification of narcissistic subtypes based on the interaction of narcissistic traits with other personality dimensions. Although clinically intuitive, Millon's typology has been critiqued for conceptual overlap between subtypes, reification of personality categories, and insufficient empirical validation of distinct subtype boundaries (Haslam, 2009; Miller et al., 2017). Subsequent research increasingly supports dimensional models—particularly the distinction between grandiose and vulnerable narcissism—which demonstrate greater empirical validity and clinical utility (Pincus & Lukowitsky, 2010; Ronningstam, 2016).

Taken together, Lowen's and Millon's models highlight the diversity of narcissistic expression but also reflect an era of personality theory centered on descriptive classification. Contemporary approaches increasingly favor dimensional, relational, and neurobiologically informed frameworks that conceptualize narcissism as a dynamic configuration of self-regulatory and interpersonal processes rather than fixed character types.

Narcissism as a Clinical and Subclinical Construct

Parallel to psychoanalysis, empirical psychology explored narcissism as both a trait and a disorder. Raskin and Hall (1979) developed the Narcissistic Personality Inventory (NPI) to measure trait narcissism, defined by egotism, dominance, and self-enhancement. Empirical findings show that narcissists initially appear charming and confident, but over time interpersonal antagonism and entitlement become salient (Back, Schmukle, & Egloff, 2010).

From Psychoanalytic Description to Diagnostic Category

Although discussions date back to Freud, narcissism entered psychiatric nosology only in 1980, when DSM-III (APA, 1980) formally introduced NPD as a distinct category. This reflected a shift from descriptive psychoanalytic accounts toward operationalized, symptom-based definitions (Akhtar, 2001; Friedman, 1989). Later editions of DSM retained NPD with nine diagnostic criteria, centering on grandiosity, need for admiration, and lack of empathy.

Contemporary Dimensional Models

In DSM-5 (APA, 2013), NPD continues as a categorical diagnosis, but the Alternative DSM-5 Model for Personality Disorders proposed trait-based dimensions. By contrast, ICD-11 (WHO, 2019) no longer lists NPD as a separate category. Instead, narcissistic features are described dimensionally across domains such as Dissociality, Anankastia, and Disinhibition. This reflects a broader transition in psychiatry from categorical diagnoses to dimensional models of personality pathology.

Subtypes of Narcissism

Building on these categorical and dimensional frameworks, some authors have emphasized the importance of subtypes of narcissism, particularly in relation to defenses against shame. Gabbard (1989) proposed two main subtypes of narcissistic personality disorder:

- The "oblivious" subtype, characterized by grandiosity, arrogance, and emotional toughness. These individuals project a larger-than-life self aimed at eliciting admiration, envy, and appreciation, while masking a fragile, shame-ridden internal self.

- The "hypervigilant" subtype, marked by hypersensitivity, vulnerability to rejection, and preoccupation with the threat of devaluation. These individuals are acutely sensitive to criticism and often perceive others as unjustly abusive or demeaning.

Contemporary research has empirically validated and expanded this distinction. Cain, Pincus, and Ansell (2008) and Pincus and Lukowitsky (2010) demonstrated that Gabbard's "oblivious" subtype corresponds to what is now described as grandiose narcissism, while the "hypervigilant" subtype parallels vulnerable narcissism. Grandiose narcissism is associated with overt superiority, dominance, and entitlement, whereas vulnerable narcissism reflects hypersensitivity, insecurity, and shame-driven withdrawal.

Modern dimensional models further emphasize that these forms are not fixed or mutually exclusive. Instead, individuals may oscillate between grandiose and vulnerable states depending on situational context and stressors (Miller et al., 2011). This perspective highlights the dynamic nature of narcissism and the importance of understanding both poles for accurate diagnosis and treatment planning.

In conclusion, the historical and theoretical development of narcissism illustrates a shift from early psychoanalytic formulations, through mid-century object-relations and self-psychology debates, to Lowen's somatic perspective, Millon's typologies, and contemporary dimensional frameworks. Contributions such as those of Kernberg (1984) and Groopman & Cooper (1998) highlight both structural models and developmental risk factors, while empirical psychology has established narcissism as both a trait and a disorder. Modern perspectives, further refined by DSM-5 and ICD-11, recognize narcissism as a heterogeneous construct encompassing grandiose and vulnerable subtypes, oscillating between defense against shame and fragile self-esteem.

The following section on Manifestation moves from theoretical formulations to clinical reality, examining how these dynamics become visible in self-image, relationships, values, sexuality, and cognition, and how the contradictions of narcissistic personality disorder unfold in everyday functioning.

Manifestation of Narcissistic Personality Disorder

Narcissistic personality disorder (NPD) is characterized by a pervasive pattern of grandiosity, need for admiration, and lack of empathy, as outlined in the DSM-5 (APA, 2013). Individuals often present themselves as ambitious and self-sufficient, yet this external image conceals a fragile self-esteem that is highly sensitive to criticism and prone to shame.

Akhtar (2001) emphasizes that narcissistic pathology manifests across several domains of functioning—self-image, interpersonal relations, social adaptation, values, sexuality, and cognition—each marked by overt confidence and covert insecurity. Friedman (1989) similarly describes grandiosity as a defensive façade, noting that behind apparent self-sufficiency lies a deep sense of emptiness and alienation. Kernberg (1984) extends this perspective by highlighting the central role of envy and aggression, which contribute to unstable relationships and fragile moral structures. In contrast, Kohut (1971, 1977) interprets these vulnerabilities as the result of disruptions in early self-object relations, leading to a chronic dependence on external validation.

In everyday life, these dynamics produce visible contradictions. Narcissistic individuals may excel professionally and socially, but their drive for success is often fueled by the pursuit of status rather than genuine fulfillment. Their moral and ideological commitments may appear enthusiastic, yet remain opportunistic and easily adjusted for approval (Millon, 1996). In intimate relationships, they may seem charming and seductive, though their capacity for deep emotional intimacy is limited, reducing bonds to sources of validation rather than authentic connection. Cognitively, they can be articulate and decisive, but their reasoning frequently lacks depth and serves primarily to reinforce their self-esteem rather than to achieve genuine understanding (Akhtar, 2001).

Contemporary research reinforces and refines these observations. Cain, Pincus, and Ansell (2008) and Pincus and Lukowitsky (2010) show that NPD manifests in two broad styles: grandiose narcissism, expressed through arrogance, dominance, and entitlement, and vulnerable narcissism, expressed through hypersensitivity, insecurity, and shame-driven withdrawal. Importantly, individuals often oscillate between these modes depending on interpersonal context and stress. Miller et al. (2011, 2017) further emphasize that these patterns are not mutually exclusive: a person may present as socially dominant in professional settings yet display vulnerable, avoidant traits in intimate relationships.

Ronningstam (2016) highlights that narcissistic functioning also has functional aspects: patients may be charismatic, productive, and socially effective. However, these qualities coexist with dysfunctional elements—exploitative behavior, inability to tolerate criticism, and chronic dissatisfaction—creating a duality that complicates both diagnosis and treatment. Similarly, Campbell and Foster (2007) note that narcissists often create strong positive first impressions, marked by charm and confidence, but over time their exploitative tendencies and lack of empathy become increasingly evident in long-term relationships.

It is important to distinguish narcissism from healthy self-esteem. While genuine self-esteem reflects an internalized and stable sense of self-worth, narcissism relies heavily on external validation and admiration. Individuals with healthy self-esteem can acknowledge limitations and accept criticism without a collapse of self-image, whereas narcissistic individuals experience even minor criticism as a profound threat, often responding with defensiveness, rage, or withdrawal (Miller & Campbell, 2008).

In sum, NPD represents a complex interplay between defensive grandiosity and underlying fragility. While outwardly marked by ambition, confidence, and apparent self-sufficiency, its core reflects a vulnerable self struggling with emptiness, envy, and dependency on external affirmation. Modern research underscores that these manifestations are fluid and context-dependent, shifting between grandiose and vulnerable states that together define the paradoxical nature of narcissistic personality disorder.

These contradictions between external grandiosity and internal fragility have prompted psychiatry and psychology to formalize criteria that can capture its core features with greater precision. As the concept moved from psychoanalytic descriptions to operationalized psychiatric frameworks, diagnostic systems such as the DSM-5 (APA, 2013) and the ICD-11 (WHO, 2019) have provided structured definitions of narcissistic personality disorder. The following section examines how NPD is defined and classified within these systems, highlighting both overlaps and divergences between the categorical and dimensional approaches to diagnosis.

Diagnosis

Narcissistic personality disorder has been conceptualized differently in current diagnostic systems. In the DSM-5 (APA, 2013), NPD remains a distinct categorical diagnosis, defined by a pervasive pattern of grandiosity, need for admiration, and lack of empathy, with at least five of nine specific criteria required for diagnosis. In contrast, the ICD-11 (WHO, 2019) does not include NPD as a separate category. Instead, it employs a dimensional model of personality disorders, where narcissistic features are described through the domains of Dissociality, Anankastia, and Disinhibition, and the diagnosis focuses on the overall severity of personality disturbance (mild, moderate, severe). This shift reflects a broader trend in psychiatric nosology from categorical to dimensional approaches.

Table 1.

Comparative Overview: DSM-5 vs ICD-11 on Narcissistic Personality Disorder

DSM-5 (2013): Diagnostic Criteria (≥ 5 of 9)	**ICD-11 (2019): Trait Domains**
1. Grandiose sense of self-importance (exaggerates achievements, expects recognition)	Primarily Dissociality (WHO, 2019)
2. Preoccupation with fantasies of unlimited success, power, brilliance, beauty, or ideal love	Anankastia component (Bach & First, 2018)
3. Belief of being "special" and unique, associating only with high-status individuals	Possible link with Disinhibition (Tyrer et al., 2019)
4. Rarely acknowledges mistakes or imperfections	

5. Requires excessive admiration
6. Sense of entitlement, expects favorable treatment
7. Exploits others to achieve their own goals
8. Lacks empathy, unwilling to recognize others' feelings/needs
9. Envious of others or believes others envy them; arrogant or haughty behaviors

Beyond its categorical and dimensional definitions, narcissistic personality disorder is also classified within Cluster B personality disorders, alongside antisocial, borderline, and histrionic personality disorders (APA, 2013). This grouping reflects their shared dramatic, emotional, and erratic interpersonal styles, yet each disorder retains distinct core features. In the following section, attention will be given to Cluster B as a whole, with a focus on the overlaps and distinctions between narcissistic personality disorder and the other disorders within this group.

NPD within Cluster B Disorders

In both DSM and ICD frameworks, narcissistic personality disorder is situated within the broader group of so-called "Cluster B" personality disorders, which are characterized by dramatic, emotional, or erratic patterns of behavior. Alongside NPD, this category includes antisocial personality disorder, borderline personality disorder, and histrionic personality disorder (APA, 2013). These disorders share certain features—such as impulsivity, difficulties in empathy, unstable interpersonal relationships, and a tendency toward manipulative or attention-seeking behaviors—yet they diverge in their core psychopathology.

Antisocial personality disorder emphasizes disregard for the rights of others, deceitfulness, and a lack of remorse, which can overlap with the exploitative and entitled aspects of NPD.

Borderline personality disorder is marked by instability in affect, identity, and relationships; though distinct, it can present with similar patterns of emptiness, shame, and fear of abandonment seen in vulnerable narcissism.

Histrionic personality disorder is characterized by excessive emotionality and attention-seeking, which parallels the admiration-seeking behaviors in NPD, albeit without the same grandiose self-concept.

Thus, the placement of NPD within Cluster B reflects its shared dramatic, emotional style and interpersonal dysfunction with these disorders, while preserving its unique core of grandiosity and self-esteem dysregulation.

The following table outlines the overlaps and distinctions between NPD and the other Cluster B disorders.

Table 2.

Overlaps and Distinctions between NPD and the Other Cluster B Disorders

Disorder	Core Features	Overlap with NPD	Distinctions
Narcissistic Personality Disorder (NPD)	Grandiosity, need for admiration, lack of empathy; fragile self-esteem masked by defensive superiority.	Shares impulsivity, manipulativeness, and unstable relationships with other Cluster B disorders.	Core feature is regulation of self-esteem through admiration and grandiosity; oscillation between grandiose and vulnerable states.
Antisocial Personality Disorder (ASPD)	Disregard for the rights of others, deceitfulness, impulsivity, irresponsibility, lack of remorse.	Both exploit others and show lack of empathy.	ASPD is rooted in disregard for social norms and aggressive violation of others' rights, while NPD is centered on self-image and entitlement.
Borderline Personality Disorder (BPD)	Affective instability, fear of abandonment, unstable identity, impulsivity, self-harm behaviors.	Both may display emptiness, shame, and unstable relationships.	BPD is dominated by fear of abandonment and emotional instability, whereas NPD is defined by grandiosity and admiration-seeking.
Histrionic Personality Disorder (HPD)	Excessive emotionality, attention-seeking,	Both seek admiration and attention.	HPD centers on emotionality and seductiveness

	superficial relationships, suggestibility.	without the grandiose self-concept characteristic of NPD.

Understanding the placement of NPD within Cluster B, and its points of overlap and divergence with related disorders, provides an important foundation for clinical practice. These insights not only refine diagnostic accuracy but also shape therapeutic strategies, which must account for both the shared features of Cluster B pathology and the specific dynamics of narcissistic functioning. The following section turns to treatment approaches, examining how psychodynamic, schema-focused, and integrative models address the challenges of working with narcissistic personality disorder.

Neurobiological and Biopsychosocial Perspectives on Narcissistic Personality Disorder

Neurobiological research has increasingly contributed to the understanding of narcissistic personality disorder (NPD), highlighting the interaction between biological vulnerability, psychological organization, and social-contextual influences within a biopsychosocial framework. Personality disorders are not merely the expression of isolated biological factors or responses to external stressors, but emerge from dynamic interactions among genetic predispositions, neural functioning, affect regulation, and interpersonal environments (Paris, 1993).

Twin studies suggest moderate to high heritability of narcissistic traits, with estimates of approximately 77% in clinical samples and 24% in the general population (Torgersen et al., 2000, 2008). Despite these findings, relatively few studies have examined the specific neurobiological mechanisms associated with NPD. Existing neuroimaging research consistently implicates dysfunctions within frontal-limbic and paralimbic networks, particularly the anterior insular cortex, a region involved in emotional awareness, empathy, norm processing, trust, and social decision-making (Gu et al., 2013; Zaki et al., 2012). Meta-analyses further demonstrate reduced gray matter volume in the left anterior insula and adjacent paralimbic regions, including the anterior cingulate cortex and medial and dorsolateral prefrontal areas (Fan et al., 2011; Schulze et al., 2013).

These structural and functional alterations are strongly associated with impairments in emotional empathy and affect regulation—core features of NPD—though their impact likely extends beyond empathy alone. From a psychosocial perspective, individuals along the NPD spectrum demonstrate disturbances in emotional reasoning, particularly in contexts involving perceived threat, unfairness, or entitlement, which contribute to maladaptive interpersonal behavior, poor decision-making, and norm violations (Ronningstam, 2016).

Treatment of Narcissistic Personality Disorder

Psychodynamic Approaches

Most psychiatrists and psychologists agree that narcissistic personality disorder (NPD) represents a relatively stable condition when it manifests as a primary personality organization. Stephen M. Johnson (1987; 1994) emphasized that psychodynamic treatment strategies should be adapted to the severity and structural level of pathology, with different interventions proving effective across the spectrum of narcissistic functioning (Kernberg, 2008).

Traditional psychodynamic approaches focus on transference dynamics and the structural organization of narcissistic pathology. Kernberg (1984, 1992, 2007), drawing on object relations theory, highlighted the central role of envy, aggression, and primitive defenses such as splitting, idealization, and devaluation in shaping the interpersonal functioning of narcissistic patients. From this perspective, narcissistic pathology reflects poorly integrated self- and object-representations, resulting in unstable self-esteem, impaired capacity for intimacy, and chronic interpersonal conflict. The primary therapeutic aim is the gradual integration of these fragmented representations, allowing for the development of a more cohesive, realistic, and stable self-structure (Kernberg, 2007; Ronningstam, 2016).

Within contemporary psychodynamic practice, these principles have been operationalized in structured treatments such as Transference-Focused Psychotherapy (TFP). TFP conceptualizes the therapeutic relationship as the primary context in which dominant internalized object relations become activated and available for systematic examination. In patients with NPD, transference manifestations often involve oscillations between idealization and devaluation of the therapist, entitlement, contempt, and heightened sensitivity to perceived humiliation or loss of control (Kernberg, 2007; Gabbard, 2014).

Countertransference reactions are particularly salient in the treatment of narcissistic patients and constitute an important source of clinical information. Therapists may experience pressure to comply with grandiose expectations, feelings of irritation, inadequacy, boredom, or rescue fantasies. Authors such as Kernberg (2007) and McWilliams (2011) emphasize that these reactions often mirror the patient's internal world and must be reflected upon rather than enacted. Maintaining a clearly structured therapeutic frame—through explicit boundaries, consistency, and an active but reflective stance—is essential for managing resistance and sustaining the therapeutic process.

Over time, successful psychodynamic work with narcissistic patients is associated with improved affect regulation, greater tolerance of ambivalence and dependency, and an increased capacity for empathy and reciprocal relationships (Ronningstam, 2016; Gabbard, 2014). Nevertheless, this approach remains clinically demanding and is often challenged by fragile therapeutic alliances and recurrent cycles of idealization and devaluation, making long-term treatment and, in some cases, adjunctive interventions necessary to ensure stability and engagement.

Cognitive-Behavioral Therapy (CBT)

In contrast to psychodynamic approaches, which emphasize personality structure, transference processes, and the integration of split self- and object-representations, cognitive-behavioral therapy (CBT) focuses on the identification and modification of maladaptive beliefs, emotional responses, and behavioral patterns that maintain narcissistic pathology. CBT conceptualizes narcissistic dysfunction primarily in terms of distorted self-appraisals, maladaptive coping strategies, and deficits in emotion regulation and

interpersonal functioning, rather than unconscious conflict or structural personality organization (Beck, Freeman, & Davis, 2004; Millon, 2011; Ronningstam, 2016).

Cognitive-behavioral therapy (CBT) for narcissistic personality disorder is a structured, goal-oriented approach that emphasizes collaboration, clearly defined therapeutic boundaries, and the gradual modification of maladaptive beliefs and behavioral patterns (Beck, Freeman, & Davis, 2004; Millon, 2011; Ronningstam, 2016). Early phases of treatment focus on establishing a workable therapeutic alliance, introducing the cognitive model, and defining realistic goals. Individuals with NPD frequently present ambivalence toward change and heightened sensitivity to perceived threats to self-esteem, which complicates engagement and requires careful pacing (Ronningstam, 2016; Caligor et al., 2015).

Because emotional vulnerability and self-disclosure are particularly challenging for narcissistic patients, behavioral interventions are often introduced before more cognitively demanding techniques. Treatment typically alternates between increasing responsibility for behavior, reducing maladaptive affective reactions such as irritability and rage, and gradually restructuring dysfunctional attitudes toward self and others (Livesley, 2003; Millon, 2011). This phased approach allows therapists to maintain engagement while addressing entitlement, hypersensitivity to criticism, and interpersonal defensiveness.

Cognitive restructuring targets rigid grandiose beliefs and dichotomous thinking patterns by encouraging patients to generate and test alternative beliefs that support a more realistic self-concept, such as tolerating imperfection and valuing cooperation over competition (Beck et al., 2003; Ronningstam, 2011). CBT interventions also address narcissistic fantasy life by replacing unrealistic, admiration-seeking fantasies with attainable and intrinsically rewarding goals, thereby shifting motivation from external validation to intrinsic satisfaction (Beck et al., 2003; Ronningstam, 2016).

Deficits in empathy and reciprocal interpersonal functioning are addressed through structured techniques such as role reversal and guided perspective-taking, which increase awareness of others' emotional experiences and promote more flexible relational patterns (Dimaggio et al., 2015; Behary & Davis, 2015). Although CBT with individuals diagnosed with NPD is clinically demanding, outcomes are more favorable when clear limits are maintained, maladaptive beliefs are systematically modified, and affective and behavioral regulation is explicitly targeted (Beck et al., 2004; Livesley, 2003; Ronningstam, 2016).

Dialectical Behavior Therapy (DBT)

Dialectical Behavior Therapy (DBT), developed within the cognitive-behavioral tradition (Linehan, 1993), represents a structured, skills-based approach originally designed to address emotional dysregulation. In the treatment of narcissistic personality disorder (NPD), DBT is not conceptualized as a primary intervention targeting personality structure, but rather as a stabilizing approach aimed at improving affect regulation and behavioral control, thereby facilitating engagement in longer-term psychodynamic or schema-focused therapies (Ronningstam, 2016; Caligor et al., 2015).

DBT focuses on four core skill domains that address areas commonly compromised in NPD. Mindfulness enhances awareness of emotional states, thoughts, and bodily reactions, providing a foundation for self-regulation. Emotion regulation strategies target intense affect such as rage and shame, while distress tolerance skills increase the capacity to endure

frustration and psychological discomfort without resorting to maladaptive behaviors. Interpersonal effectiveness training supports the development of more adaptive communication, boundary-setting, and reciprocal relating (Linehan, 2015).

By reducing affective escalation, impulsivity, and interpersonal disruption, DBT helps contain behaviors that frequently interfere with therapeutic engagement. Within an integrative, phase-based model of treatment, DBT is therefore most effective as an adjunctive intervention that supports emotional stability and prepares patients with NPD for more expressive psychodynamic work focused on identity diffusion, aggression, and maladaptive relational patterns.

Schema Therapy

In recent decades, increasing attention has been directed toward cognitive-emotional perspectives in the understanding of narcissistic pathology. In this vein, Jeffrey Young (1994) identified the central role of shame in NPD, conceptualizing the Defectiveness/Shame Schema as a core feature, alongside Emotional Deprivation and Entitlement Schemas. These maladaptive schemas give rise to three coping modes:

- Surrender: choosing critical or demeaning partners and internalizing negative self-views.
- Avoidance: withholding emotions or thoughts to prevent anticipated rejection.
- Overcompensation: adopting superiority or perfectionism to mask inner vulnerability.

Not all patients display all three coping responses, but they represent defensive adaptations to underlying feelings of inadequacy. This aligns with schema therapy formulations (Young, Klosko, & Weishaar, 2003; Arntz & Jacob, 2012), which describe maladaptive schemas as the drivers of narcissistic defenses. From this perspective, narcissistic behaviors—whether arrogant and dismissive or withdrawn and insecure—function as strategies to regulate fragile self-esteem and defend against chronic shame.

Techniques and Efficacy of Schema Therapy

Schema therapy is particularly valuable for patients who struggle with chronic instability of self-esteem and difficulties in forming authentic relationships. In clinical work with narcissistic patients, schema therapy requires a therapeutic stance that balances empathic attunement with firm limit-setting, particularly in addressing entitlement, avoidance of vulnerability, and shame-based coping modes (Behary, 2008; Behary & Davis, 2015). It combines cognitive, behavioral, experiential, and attachment-focused techniques such as:

- Emotional awareness and mindfulness to recognize maladaptive patterns.
- Limited reparenting to provide corrective emotional experiences.
- Imagery rescripting to reprocess traumatic early experiences.
- Experiential exercises to develop healthier modes of relating to self and others.

Modern adaptations (Arntz & Jacob, 2012; Bamelis, Evers, Spinhoven, & Arntz, 2014) have demonstrated the effectiveness of schema therapy in treating a range of personality disorders, including NPD. Randomized controlled trials show that these interventions help patients recognize and modify shame-based schemas, build healthier coping strategies, and develop a more stable and authentic sense of self-worth.

Existential Perspectives

From an existential perspective, narcissistic pathology is understood not primarily as excessive self-regard, but as a defensive response to diminished self-awareness and confrontation with existential concerns such as isolation, mortality, freedom, and meaninglessness. Irvin Yalom (1980) conceptualized grandiosity as a defense against existential anxiety and isolation, noting that narcissistic patients often avoid authentic relatedness in order to preserve a sense of invulnerability. Similarly, James Bugental (1999, 2000) described such individuals as living with reduced experiential awareness, operating "on automatic pilot" and remaining disconnected from their immediate emotional experience. Contemporary existential authors, including Kirk Schneider (2008, 2010) and Emmy van Deurzen (2010, 2016), further emphasize narcissistic functioning as a crisis of meaning and identity shaped by cultural emphasis on image and external validation. Within this framework, therapeutic change emerges through expanded self-awareness, presence, and engagement with existential realities rather than direct modification of narcissistic defenses.

Integrative Perspectives

Contemporary clinical practice increasingly emphasizes integrative approaches in the treatment of narcissistic personality disorder (NPD), reflecting the recognition that narcissistic pathology is heterogeneous and cannot be adequately addressed through a single therapeutic model. Integrative frameworks combine psychodynamic formulations of personality structure and relational patterns with schema-focused, cognitive-behavioral, and skills-based interventions, allowing treatment to be tailored to the patient's dominant narcissistic configuration and level of functioning (Ronningstam, 2016; Caligor, Levy, & Yeomans, 2015).

Within such models, treatment is often phase-based. In early stages, structured interventions derived from Cognitive-Behavioral Therapy or Dialectical Behavior Therapy are used to stabilize affective dysregulation, reduce impulsive or maladaptive behaviors, and support therapeutic engagement. As emotional regulation and relational stability improve, more expressive psychodynamic work can be gradually introduced to address deeper issues of identity diffusion, aggression, and maladaptive relational patterns enacted within the therapeutic relationship (Clarkin, Yeomans, & Kernberg, 2006; Yeomans et al., 2015).

Overall, although the treatment of NPD remains clinically demanding, integrative psychotherapy offers a coherent framework for addressing both defensive grandiosity and underlying psychological fragility. By flexibly sequencing interventions and adapting therapeutic focus to the patient's predominant patterns, integrative approaches increase the likelihood of sustained engagement, improved affect regulation, and more adaptive interpersonal functioning.

From an integrative viewpoint, psychotherapeutic change may be understood as facilitating greater coherence between limbic affective systems and prefrontal regulatory processes, reflected in improved capacities for emotion regulation, self-reflection, and interpersonal functioning (Schore, 2003; Northoff et al., 2006). Although the precise neural mechanisms of change remain under investigation, converging theoretical and empirical evidence suggests that diverse psychotherapeutic approaches—psychodynamic, cognitive-behavioral, schema-based, and skills-focused—may promote clinical improvement through shared pathways involving affect regulation, self-coherence, and social-cognitive functioning (Fonagy & Target, 2002; Cozolino, 2010; Caligor, Levy, & Yeomans, 2015; Ronningstam, 2016).

Conclusion

Narcissistic personality disorder remains a significant clinical and theoretical challenge due to its complex presentation, heterogeneity, and substantial impact on interpersonal functioning and psychological well-being. The findings reviewed in this paper support the view that NPD is not defined by genuinely elevated self-esteem, but rather by maladaptive self-regulatory processes rooted in vulnerability, internalized shame, and reliance on external validation. Understanding the distinction between healthy narcissism, self-esteem, and pathological narcissism is therefore essential for both accurate diagnosis and effective clinical intervention. Despite ongoing debates surrounding classification and treatment, converging evidence from psychodynamic, cognitive-emotional, and neurobiological research underscores the importance of viewing NPD as a multidimensional condition shaped by the interaction of early relational experiences, psychological defenses, and biological vulnerability. While therapeutic engagement is often complicated by resistance, entitlement, and fragile self-esteem, contemporary clinical approaches suggest that meaningful change is possible when treatment is flexibly tailored to individual patterns of functioning. Future research should continue to integrate neurobiological findings with psychological and interpersonal models in order to refine both diagnostic frameworks and treatment strategies. Overall, NPD demands an integrative and nuanced approach that acknowledges the interplay between self-concept, affect regulation, and relational dynamics, thereby supporting more effective and ethically grounded clinical practice.

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