Narcissistic personality disorder: Treatment overview

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INTRODUCTION

Narcissistic personality disorder (NPD) is characterized by grandiosity, which may be overt or covert, an urgent need for attention and praise, superficial interpersonal relationships, and a lack of empathy [1].

One of the least studied personality disorders, NPD appears to be prevalent, highly comorbid with other psychiatric disorders, and associated with significant impairment and psychosocial disability. NPD presents several challenges to clinicians. It has a variable presentation. There is disagreement over how to define the boundaries of the disorder, leading to lack of clarity with regard to its diagnostic criteria, epidemiology, and course. NPD is difficult to treat and complicates the treatment of commonly co-occurring disorders.

The treatment of NPD is described here. The epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis of NPD are described separately. The epidemiology, clinical manifestation, assessment, diagnosis, and treatment of other personality disorders are also described separately. Pharmacotherapy for personality disorders is reviewed separately.

- (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)
- (See "Overview of personality disorders".)
- (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)
- (See "Borderline personality disorder: Psychotherapy".)

- (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)
- (See "Antisocial personality disorder: Treatment overview".)
- (See "Personality disorders: Overview of pharmacotherapy".)

APPROACH TO TREATMENT

Psychotherapies and medication treatments for narcissistic personality disorder (NPD) are still in early stages of development and testing, with a lack of clinical practice guidelines with specific treatment recommendations [2]. Based on anecdotal reports, psychotherapeutic approaches and medications used in practice appear to vary widely.

For patients with NPD, we suggest first-line treatment with psychotherapy rather than medication. Research data are not adequate to inform selection of a particular type of psychotherapy. In our clinical experience, a psychotherapeutic approach based on the objectives and techniques of supportive psychotherapy and applied to the needs of NPD patients may be most helpful.

Several manualized psychotherapies that have shown efficacy in borderline personality disorder (another “cluster B” disorder with some similarities to NPD) have been adapted to treat NPD, but the research is at an early stage and the models have not been widely disseminated. (See 'Supportive psychotherapy' below and 'Structured psychotherapies' below.)

Some NPD patients, in our clinical experience, may benefit from adjunctive medication treatment, including patients with:

- **Severe NPD symptoms that pose a risk to safety** – Gross affective instability, impulsive anger and aggressiveness, or cognitive-perceptual disturbances are sometimes seen in patients with severe NPD or severe borderline personality disorder. These presentations have been treated with mood stabilizers, antidepressants, and antipsychotic drugs. (See 'Severe NPD with safety risks' below and "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)

  Medications for these symptoms have not been studied in patients with NPD, but have been subject to clinical trials in patients with borderline personality disorder. Our clinical experience in NPD and meta-analyses of the trials in borderline personality disorder support preferred use of the following drug classes for the targeted symptoms [3-5] (see "Borderline personality disorder: Treatment overview"):

- Gross affective instability – Mood stabilizers appear to be more effective and better tolerated in borderline personality disorder compared with antipsychotic medications or antidepressants. As examples, we have the most experience with topiramate (mean daily dose 200 to 250 mg) and valproate (mean daily dose 850 mg, mean serum level 65 mcg/mL).

- Impulsive anger and aggressiveness – Mood stabilizers and antipsychotic drugs have been found to be similarly efficacious in borderline personality disorder, more so than antidepressants. Antipsychotic drugs allow a rapid titration and have rapid effect; lower doses are typically needed compared with dosing for psychotic disorders.

  Examples include the mood stabilizers topiramate (mean daily dose 200 to 250 mg) and valproate (mean daily dose 850 mg, mean serum level 65 mcg/mL), and the antipsychotic aripiprazole (mean daily dose 15 mg), which has a lower risk of causing metabolic side effects compared with other second-generation antipsychotic drugs.

- Cognitive-perceptual disturbances – Cognitive-perceptual disturbances in patients with borderline personality disorder have responded better to antipsychotic drugs compared with mood stabilizers or antidepressants. An example is aripiprazole (mean daily dose 15 mg).

- **Treatment of co-occurring disorders** – Standard medications or evidence-based psychotherapies should be used to treat co-occurring mental disorders (eg, generalized anxiety disorder or major depression) in patients with NPD. (See 'Co-occurring disorders' below and "Unipolar major depression in adults: Choosing initial treatment" and "Generalized anxiety disorder in adults: Management".)

GENERAL PRINCIPLES

Narcissistic personality disorder (NPD) 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 suggest:

Discussing the diagnosis — Discussing the diagnosis of NPD with the patient is a necessary component of informed consent to treatment, particularly a treatment as long and difficult as treatment of NPD may be. With a comprehensive diagnosis, the clinician can present the patient

with a rational treatment frame and realistic expectations; without it, patients are vulnerable to polypharmacy or multiple courses of ineffective psychotherapies or polypharmacy that accumulates while chasing refractory symptoms [1].

Disclosing to patients that they meet criteria for NPD and other personality disorders has been much debated. Some patients experience the diagnosis as a humiliating label of an untreatable illness with little hope of recovery. In our clinical experience, however, many patients with a personality disorder are relieved to learn that they do not have, for example, a refractory mood disorder, but instead have a characterological diagnosis that is well defined, and for which there exists potentially effective treatment. As knowledge about personality disorders has increased, and treatments are under development and testing, clinicians can discuss with their patients etiologic models, clinical features, course, and treatment options for personality disorders; in many cases they can offer genuine hope of symptom reduction and even lasting personality change [6-8].

While these factors are generally true for all personality disorders, NPD remains a potentially problematic label. Patients increasingly come to us aware of the diagnosis, often from internet searches or from other clinicians. These individuals are typically reassured by a clinician's thoughtful, empathic explanation and discussion of the diagnosis. In our clinical experience, for patients unaware of the diagnosis, a useful approach to sharing diagnostic impressions has been to:

- Focus initially on the core dysfunctions and distress that characterize personality disorders as a group. (See "Overview of personality disorders", section on 'Clinical manifestations'.)
- Address the characteristics associated specifically with NPD: problems with self-esteem regulation, difficulty with intimacy, feelings of emptiness. This can be done without introducing the term "narcissistic personality disorder."
- Many patients will inquire about what kind of personality disorder they have. At this point an honest, neutral discussion of NPD can for many patients be the first step in developing a treatment alliance.
- With patients who do not ask for more information, it may be helpful to downplay or even avoid the term "narcissistic personality disorder" until the patient expresses curiosity or until the treatment has advanced to a stable alliance.

Forming an alliance — Patients with NPD typically show reluctance to begin treatment and resistance to engaging in treatment. Early in treatment, communicating empathy while focusing on specific treatment goals can help foster the development of an alliance. It is

especially useful to address the negative feelings that the patient may have about the treatment and about the clinician; such discussion can lead to exploration of the motivations for the patient's negative responses to others and, ultimately, to themself. We suggest that clinicians use the patient's words whenever possible, and preface interventions with comments such as, "As you said earlier," to help NPD patients more readily accept the clinician's comments and recommendations. (See "Approaches to the therapeutic relationship in patients with personality disorders".)

Effective psychotherapy with NPD patients requires that clinicians maintain a nonjudgmental and inquisitive stance toward the patient's difficulties; patients will better engage if their perceptions of the world and of others, including of the clinician themself, are approached with curiosity and tolerance. Early confrontations of the patient's grandiosity are likely to be unproductive.

Clinicians' reactions to patients with NPD tend to be powerful and typically negative; experienced clinicians anticipate that they will have to monitor and contain their emotional reactions to the patient. Patients may begin treatment with idealizations or haughty, contemptuous devaluations of the therapist, both of which can be difficult for the therapist to tolerate; alternatively, the patient may vacillate quickly between idealization and devaluation. Common pitfalls 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.

When establishing an alliance it is often best to "go with" the patient's initial construction of the treatment relationship rather than attempting to correct the patient's distortions. The rationale is that these constructions serve important functions, helping the patient with NPD to tolerate the "humiliation" of coming for help, and may enable the individual with NPD to more smoothly settle into treatment. The tactic of "going with" the patient's distortions of the therapeutic relationship calls on clinicians to allow some patients to grossly idealize them, other patients to aggressively devalue them, and still others to construct a relationship between "buddies." Over time it often becomes possible for the clinician to gently and incrementally introduce a more realistic perspective of the doctor-patient relationship, once the initial hurdle of establishing an ongoing treatment has been surmounted.

The grandiosity and defensiveness that characterize NPD across the spectrum of severity make engagement in any form of psychotherapy difficult; in some studies dropout rates are as high as 64 percent. Any effective treatment will need to address core attachment difficulties as a part of treatment planning [9,10]. Therapists may need to avoid confronting gross idealization or devaluation, for example, to support patients' grandiosity until the treatment has consolidated.

NPD patients often experience help and even positive change as humiliating dependence and weakness, which can confuse and unsettle practitioners inexperienced with NPD pathology [11].

PSYCHOTHERAPIES

No structured psychotherapies have been tested in randomized clinical trials of patients with narcissistic personality disorder (NPD).

Supportive psychotherapy — The objectives and techniques of supportive psychotherapy provide a basis for treating NPD. Supportive psychotherapy is a pragmatic approach that, as most commonly practiced, makes use of both psychodynamic and cognitive behavioral techniques, and it is often combined with psychopharmacologic management. Supportive psychotherapy can be structured as a short-term intervention to manage acute crises and/or deterioration in functioning, or as an ongoing maintenance treatment [12].

The goals of supportive psychotherapy with NPD are to stabilize the patient, treat comorbidities, and help the patient to attain the highest possible level of functioning given the constraints of the patient's personality pathology.

Supportive psychotherapy focuses on establishing and maintaining a treatment alliance, providing the patient with an understanding of his diagnosis and his problems, helping the patient to develop a more complete awareness of maladaptive behaviors, and working with the patient to identify realistic, attainable treatment goals. The therapist establishes a collaborative, collegial relationship with the patient, in which the therapist provides encouragement, reassurance, advice, and coaching, while modeling adaptive behavior.

Supportive psychotherapy frequently involves skills training, often focusing on affect regulation and managing destructive impulses, development of social skills, and managing negative cognitions. Meeting with the patient's family and/or significant others is frequently integrated into the treatment. (See "Unipolar depression in adults: Supportive psychotherapy".)

Structured psychotherapies — Four manualized psychotherapies with evidence of efficacy in borderline personality disorder have been adapted for the treatment of NPD: mentalization-based therapy [13], transference-focused psychotherapy [14,15], schema-focused psychotherapy [16], and dialectical behavioral therapy. All are long-term treatments that require the therapist to obtain specialized training to deliver. None of them have been rigorously tested in patients with NPD or the subject of widespread clinician training, greatly limiting their available for the disorder.

Clinical experience and limited research on structured psychotherapies for patients with borderline personality disorder with and without co-occurring NPD has not been encouraging. Patients with co-occurring disorders generally do worse in psychotherapy compared with patients with borderline personality disorder alone. The pathologic grandiosity of NPD is maladaptive and rigid but can be paradoxically organizing in borderline patients, giving the illusion of stability, and making treatment seem less urgent. NPD patients pathognomonically resist meaningful involvement with others, including therapists, and treatment can remain superficial for long periods and may never advance [17].

Mentalization-based therapy — Mentalization-based therapy derives from attachment and cognitive theory and identifies problems in early attachment as the source of adult impairments in mentalization: the ability to accurately experience mental states in oneself and in others, and to recognize how mental states determine behavior. Patients in mentalization-based therapy are first taught to improve their capacity to self-reflect, and then to use self-reflection to assess and alter their subjective experience of self and others [13]. Given narcissistic patients' impoverished capacity for self-reflection and attachment, mentalization-based therapy is a promising adaptation for NPD.

Transference-focused psychotherapy — Transference-focused psychotherapy is a manualized, individual psychodynamic treatment; its core principles have been adapted to treat a wider range of pathologies, including NPD [14,18].

Transference-focused psychotherapy begins with an explicit diagnostic and treatment formulation, followed by establishing a treatment contract, a verbal agreement between therapist and patient that articulates the responsibilities each shares in the therapy. Transference-focused psychotherapy identifies the patient's treatment goals (eg, personal, romantic, and professional), and returns to them as a touchstone throughout the therapy. The contract includes provisions for threats to the treatment goals, such as unemployment or illegal behavior.

Charged affective experiences and cognitive distortions characterize "cluster B" personality disorders as a group. The contract obligations tend to activate these experiences and distortions in treatment. When they occur in treatment and are played out in relation to the therapist, they can be identified and then explored and understood.

The contract requires the patient's participation in setting treatment goals; a result is that narcissistic patients are less likely to feel the treatment is focused on the clinician's arbitrary mandate or agenda. The contract can act as a "third party," diffusing the direct antagonism and hostility that frequently erupt in NPD therapies. An emphasis on patient-therapist interactions

provides narcissistic patients opportunity to become aware of their grandiosity and antagonism on the one hand, and their vulnerability and fears of humiliation on the other, in the protected setting of a relationship with an empathic clinician.

Schema-focused psychotherapy — Schema-focused psychotherapy combines the precepts of cognitive-behavioral therapy (CBT), attachment theory, and psychodynamic therapy to treat structures referred to as maladaptive schemas. Maladaptive schemas are pervasive negative perceptions of self, of others, and of one's place in the world that are embedded in early life [16]. Pathology occurs when these dynamics are activated by life events in adulthood. In patients with NPD, schema-focused psychotherapy addresses core schemas of narcissism: emotional depravation, defectiveness, and entitlement [19]. In schema focused therapy, therapists enact a limited "reparenting" to replace maladaptive schemas with healthy behavioral and cognitive models [20,21].

Schema-focused therapy may be well suited for NPD patients, who generally have difficulty tolerating psychotherapy and remaining in treatment. A clinical trial in patients with borderline personality disorder suggested that schema-focused therapy may have a lower dropout rate compared with other approaches [20].

Dialectical behavioral therapy — Dialectical behavioral therapy (DBT), a form of CBT that combines individual therapy with group treatment, has core principles of acceptance ("radical acceptance") and change. The efficacy of DBT in borderline personality disorder is well established. (See "Borderline personality disorder: Psychotherapy", section on 'Dialectical behavior therapy'.)

Suggesting promise in treating NPD, the therapy emphasizes mentalization skills and techniques for affective regulation, a prominent area of vulnerability in narcissistic patients [22,23]. Mentalization is the ability to accurately experience mental states in oneself and in others and to recognize how mental states determine behavior.

We have found DBT useful to manage self-destructive behavior in patients with comorbid borderline personality disorder and NPD, an important skill set given the high rate of comorbidity between the two disorders [24]. (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis", section on 'Comorbidities'.)

PHARMACOTHERAPY

In our clinical experience, medication use in patients with narcissistic personality disorder (NPD) is best kept to a minimum, used for:

- Severe NPD symptoms that pose a risk to safety
- Treatable co-occurring psychiatric disorders

There are no clinical trials of medication efficacy in the treatment of NPD and no medications are approved for use in the disorder by the US Food and Drug Administration.

Severe NPD with safety risks — A medication trial may be warranted when a patient with NPD presents with severe symptoms that pose risks to safety (ie, gross affective instability, impulsive anger and aggressiveness, or cognitive-perceptual disturbances). The efficacy of medication in NPD is supported by our clinical experience and, indirectly, by clinical trials of medication for these symptoms in borderline personality disorder. Meta-analyses of clinical trials of medications for borderline personality disorder support the efficacy of the following drug classes for the targeted symptoms [3-5]:

- Gross affective instability – Mood stabilizers (moderate to large clinical effects), antidepressants (small to moderate clinical effects).
- Impulsive anger and aggressiveness – Mood stabilizers (large clinical effects), antipsychotics (large clinical effects).
- Cognitive-perceptual disturbances – Antipsychotics (moderate clinical effects).

The efficacy of mood stabilizers, antidepressants, and antipsychotic drugs for targeted symptoms in borderline personality disorder are reviewed in more detail separately. (See "Borderline personality disorder: Treatment overview".)

Co-occurring disorders — Medications are used to treat major depression and anxiety disorders that occur concurrently with NPD. Clinical trials have not examined this use with NPD, though trials in borderline personality disorder patients with co-occurring disorders provide some evidence of efficacy [4,25]. (See "Personality disorders: Overview of pharmacotherapy" and "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis", section on 'Comorbidities'.)

Anticipate that co-occurrence of NPD will complicate treatment, making it more difficult to establish and maintain a therapeutic alliance, and increasing the likelihood of dropout or poor treatment response. Treatment of more commonly co-occurring disorders are reviewed separately.

Unnecessary medication use or polypharmacy can easily occur in the treatment of NPD, because the aggression and distress characteristic of some NPD patients can induce anxiety and desperation in clinicians. Narcissistic patients are also at risk of undertreatment; they often experience the suggestion of medication as a narcissistic injury and may reject it. To avoid conflict, clinicians may unconsciously avoid recommending medication, even to NPD patients with a highly symptomatic, treatable co-occurring disorder.

MANAGING NPD IN MEDICAL CARE

Outside of mental health specialty care, where clinicians have a treatment frame and objective to treat narcissistic personality disorder (NPD), clinicians in other areas of medicine may be confronted with the need to manage narcissistic aggression. Narcissistic behaviors can:

- Disrupt medical care
- Exhaust medical practitioners and staff
- Consume time and other resources

Features of the psychotherapies described here can be adapted to clinical settings outside of mental health. These adaptations are not designed to treat personality disorders (substantive character change can require long-term, high-frequency therapy) but they can help contain NPD-related disruptions or threats to medical care [26]:

Making a contract — The treatment contract in transference-focused psychotherapy is a dialogue between the patient and the clinician rather than a list of rules or demands enforced on the patient. As a "third party," it can neutralize the antagonistic dyads narcissistic patients create between themselves and others. The following example illustrates how a contract might work:

- Mr. X, a 56-year-old patient with Crohn disease, has frequently missed appointments, demands treatment he finds on the internet instead of the medications prescribed by his clinicians, and pays his bills late. When confronted with these behaviors, he shouts: "I miss appointments because you're useless, you're even worse than my last two doctors! I read about all these new treatments, why aren't I getting them? You doctors make a fortune; why should I give you my money?"

There are several problems the clinician might address here, but an effective contract generally begins with the patient's behavior and affect; in this case, the patient's aggression. A starting point might be:

- "I hear that you worry I can't help you, and we need to talk about that. But before we discuss that we should talk about the way you communicate with me. It's a real struggle for me to think when you're shouting at me, can you understand that? I lose focus, and I can't give your problems my full attention when I feel intimidated. Since we both want the same thing, can we agree that you won't shout at me when you come to your appointments?"

It would be naïve to expect that angry, entitled patients will calmly agree and end hostilities. Caregivers need to revisit the agreement multiple times until patients accept that their behavior interferes with their care.

It is pathognomic that narcissistic patients will challenge restrictions on their behavior. These challenges allow the contract to become a third party of sorts, which deflects the patient's aggression away from the caregiver and toward the agreement:

- "I hear that you're frustrated, but do you remember our agreement? Last time, we had an understanding that shouting prevents me from thinking clearly and distracts us both from concentrating on your medical concerns. I think you really got how important that was. Can we go back to that agreement to help us work together?"

  "But I'm really angry; nothing you're doing is making any difference! Of course I'm shouting!"

  "Yes, I know, this treatment hasn't worked as we'd hoped. We need to have a plan, but right now we need to discuss the way we communicate so that I can be at my best."

  This process will likely need to be repeated; if the patient's aggressive behavior comes under control, the other issues (missed appointments, devaluing remarks, late payment) can be addressed.

Documentation — Medical and surgical practitioners can be especially reluctant to "label" patients with personality disorders in medical records, particularly with NPD. Anecdotally, caregivers cite concerns that their notes will convey their own frustration and anger toward these difficult patients, whose aggression, devaluation, and nonadherence to medical treatments or advice can activate strong negative reactions in treatment providers. On the other hand, it is well documented that personality disorders consume inordinate time and resources and cause potentially dangerous disruptions in medical care [27]; it seems problematic to omit these systemic threats to care in patient records.

We recommend that a standardized template be used in those cases in which narcissistic symptoms have interfered with clinical care: Standardization can be a protective filter, limiting potential telegraphing of negative feelings in the medical chart, and the description of narcissistic symptoms can feel less pejorative if focusing on how symptoms have obstructed medical care. An example is as follows:

- “I am treating Mr. X for Crohn Disease. He has been combative, has missed appointments, and has been nonadherent with medication and preventive care. He devalues my treatment suggestions and claims to have more knowledge of his medical conditions than I have. He missed his colonoscopy this month and attributes his missed appointment to my shortcomings and the shortcomings of his family. This pattern of behavior in Mr. X is most consistent with a personality disorder; personality disorders are generally known to interfere with medical care, as they have for Mr. X in this case. It is likely that his behavior will continue to compromise his treatment for Crohn disease if his behavior remains unchanged.”

SOCIETY GUIDELINE LINKS

Links to society and government-sponsored guidelines from selected countries and regions around the world are provided separately. (See "Society guideline links: Personality disorders".)

SUMMARY AND RECOMMENDATIONS

- For patients with narcissistic personality disorder (NPD), we suggest first-line treatment with psychotherapy rather than medication (**Grade 2C**). Research data are not adequate to inform selection of a particular type of psychotherapy. In our clinical experience, a psychotherapeutic approach based on the objectives and techniques of supportive psychotherapy and applied to the needs of NPD patients may be most helpful. (See 'Approach to treatment' above and 'Supportive psychotherapy' above.)

- Several structured, manualized psychotherapies that have shown efficacy in borderline personality disorder, another “cluster B” disorder with some similarities to NPD, have been adapted to treat NPD, but the research is at an early stage and the models have not been widely disseminated. (See 'Approach to treatment' above and 'Structured psychotherapies' above.)

- The grandiosity and defensiveness that characterize NPD across the spectrum of severity make engagement in any form of psychotherapy difficult. Engagement may be

challenging using a structured psychotherapy; in trials in patients with borderline personality disorder, dropout rates as high as 64 percent were seen.

- Patients with NPD typically show reluctance to begin treatment and resistance to engaging in treatment. Early in treatment, communicating empathy while focusing on specific treatment goals can help foster the development of an alliance. Effective psychotherapy requires that clinicians maintain a nonjudgmental and inquisitive stance toward the patient's difficulties. Early confrontations of the patient's grandiosity are likely to be unproductive. (See 'Forming an alliance' above.)

- Adjunctive medication treatment may be helpful for patients with severe NPD symptoms that pose a risk to safety (see 'Approach to treatment' above and 'Severe NPD with safety risks' above):

  - Gross affective instability – Mood stabilizers; we have the most experience with topiramate and valproate in NPD.

  - Impulsive anger and aggressiveness – Mood stabilizers or antipsychotics. As an example, the antipsychotic, aripiprazole, has a lower rate of metabolic side effects compared with other second-generation antipsychotics.

  - Cognitive-perceptual disturbances – Antipsychotics.

- NPD patients with co-occurring psychiatric disorders such as major depression or generalized anxiety disorder should be treated with standard, evidence-based medications or structured psychotherapies specific to the disorder. (See 'Approach to treatment' above and 'Co-occurring disorders' above and "Unipolar major depression in adults: Choosing initial treatment" and "Generalized anxiety disorder in adults: Management".)

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